2020 CAMPER APPLICATION

A $50.00 application fee is required with each application.
Make check payable to: Camp CaPella

If we are unable to accommodate your request, half of the application fee received will be returned.

Please read carefully.
Incomplete applications will not be processed.
Please do not omit information.

Important Information:

ALL APPLICATIONS MUST BE RECEIVED BY MARCH 13, 2020

- Applications are reviewed carefully and information requested is used by staff to determine if Camp CaPella is a good fit for your camper.
- Space is limited and many factors are taken into consideration.
- Campers are accepted and placed in what we believe will offer them the best camp experience possible.
- If you have any questions and/or concerns, please do not hesitate to reach out.

Applications received AFTER March 13th, will be processed on a first come basis, as space is available.

Return completed application to:

Camp CaPella
Heidi Riggs, Camp Director
PO Box 552, Holden, ME 04429
Fax: 207-843-7413
Email: heidi@campcapella.org

For Questions:
Call Camp at 207-843-5104
Heidi Cell at 207-479-0442 or
Email heidi@campcapella.org
Camper Eligibility Policy

Please read carefully. In order to attend Camp CaPella, all campers must be able to meet the following requirements. Contact us if you have questions about your camper’s eligibility.

The camper:

- Must have a primary diagnosis of an intellectual and/or physical disability, and is otherwise unable to attend a traditional summer camp program.

- Day campers start at age 5. Overnight campers start at age 8. There will be separate weekly sessions for campers based on age.

- Must be able to interact with others, individually or with assistance, and participate in the camp program.

- **Must be free of physically aggressive behaviors.**

- Must be able to adapt to staff supervision ratio of one staff to three campers. We are prepared to provide 1:1 care when needed for personal care, such as feeding, toileting, bathing, etc. *We do not have the resources to serve campers who require constant 1:1 supervision and/or care throughout their stay at camp.*

- **We cannot accept campers with emotional disturbance disorders.**

- Applicants who will be accompanied by a medical caregiver because of their specific medical needs will be considered on an individual basis.

I agree that ________________________________ meets the above requirements to attend

(Camper Name)

Camp CaPella.

Print Name ________________________________ Relationship to Camper ________________________________

Signature ________________________________ Date ________________________________
Camper Information (print clearly)

Name: ________________________________________________________________

Diagnosis: ___________________________________________________________________

Age: _____ D.O.B. ____________________ Male ___ Female ___

Address: _____________________________________________________________________

Town: ________________________________ State: ________ Zip: __________

Home Phone: _________________________ Cell Phone: _________________________

Email: _____________________________________________________________________

School or Program Attended: _________________________________________________

Does camper require 1:1 support in school and/or program setting? YES NO

Emergency Contact: _______________________________________________________

Case Manager Name: ______________________________________________________

Agency: ________________________________________________________________

Case Manager Email: ______________________________________________________

Office Phone: ________________________ Cell Phone: _________________________

I give permission for Camp CaPella to speak with case manager if needed.

________________________________________________________________________

Signature Date

Parent/Guardian Information

Name: _____________________________________________________________________

Relationship to Camper: _____________________________________________________

Address: __________________________________________________________________

Town: ________________________________ State: ________ Zip: __________

Home Phone: _________________________ Cell Phone: _________________________

Work Phone: _________________________ Place of Employment: __________________

Email: _____________________________________________________________________

Preferred Method of Contact: ________________________________________________

Best Time To Contact: ______________________________________________________
Parent/Guardian Information

Name: __________________________________________________________________

Relationship to Camper: __________________________________________________________________

Address: __________________________________________________________________

Town: ______________________________ State: __________ Zip: _________________

Home Phone: ________________________  Cell Phone: ________________________

Work Phone: ________________________  Place of Employment: _____________________

Email: _____________________________________________________________________

Preferred Method of Contact: __________________________________________________

Best Time To Contact: _______________________________________________________

If parent/guardian cannot be reached, who can we contact, in order of preference:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number(s)</th>
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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number(s)</th>
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</table>

While at camp, parent/guardian will be:

_______ At home

_______ On vacation and may be reached at ___________________________ dates _____________

Persons camper can be released to:

__________________________________________________________________________

__________________________________________________________________________

Persons camper MAY NOT be released to:

__________________________________________________________________________
**Please Note:** As you complete the camper application, please keep in mind that Camp CaPella is an accessible recreational opportunity in which campers participate in a wide variety of activities that may include swimming, boating, recreational games, music, arts-n-crafts, as well as, daily special events. During these activities we will provide a 1:3 staff to camper ratio.

*If camper requires 1:1 supervision in order to participate, for safety or behavior, you must provide an individual support person to attend with your camper.*

Please carefully consider all questions and do not omit information. Incomplete applications will not be processed.

Feel free to use additional paper if you need more space.

**PLEASE CHECK THE FOLLOWING STATEMENT AS IT APPLIES TO YOUR CAMPER**

______ I feel comfortable this camper will participate in camp activities in a safe and appropriate manner, and will be adequately cared for by our 1:3 staff to camper ratio.

______ I feel, at certain times, a 1:3 ratio will not be adequate supervision. Please list reasons for additional assistance below.

______ I feel this camper is always in need of 1:1 supervision. An individual support person will accompany this camper. Please complete additional information below.

My camper will need additional assistance at times for: ________________________________

_____________________________________________________________________________

_____________________________________________________________________________

An individual support person will attend with my camper. YES NO

Name of support person:

____________________________________________________________

Agency: _________________________________ Phone: _____________________________
Health, Behavior, Skills and More

To be completed by primary caregiver and submitted with application. Please print clearly.

Camper name: ________________________________________________________________

Disability/Diagnosis: ____________________________________________________________________________________________

Mobility: please check all that apply
___ Ambulatory
___ Uses Wheelchair
___ Transfer Assistance
___ Ambulatory with assistance
   ___ Staff assistance
   ___ Cane/Walker
   ___ AFO (Type:_______)
___ Manual chair
___ Power chair
___ Independent
___ Can propel self? Y  N
___ 1 person pivot
___ 2 person pivot
___ Hoyer Lift

Activities of Daily Living/Personal Care (please check all that apply)

<table>
<thead>
<tr>
<th>Dressing</th>
<th>Independent</th>
<th>Verbal Prompts</th>
<th>Hand Over Hand</th>
<th>Total Assist</th>
<th>Describe Assistance Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tie shoes</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Button/Zipper</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Showering

Shampoos hair |              |              |              |              |                             |
Wash with asst |             |              |              |              |                             |

Teeth |              |              |              |              |                             |

Toileting

Aids used (circle one) | Independent, no concerns | Reminders to use bathroom | Assistance with wiping |
Depends When? | Bedpan/Urinal (you bring) | Toilet chair | Other: |
Bladder control (circle one) | Continent | Occasional accidents | Incontinent | Catheter & Type: |
Bowel control (circle one) | Continent | Occasional accidents | Incontinent | Bowel Program |

Eating

Independent, no Concerns | Needs prompts to eat | Needs to be fed |

Utensils
Conventional utensils | Adaptive utensils (you bring) | Finger foods only |

Dietary Needs
Cut into bite size pieces | Mechanically chopped diet only | Pureed diet only |

Gluten Free | Dairy Free | G- Tube | Other: |
For those campers on a gluten/dairy free or other restrictive diet, we will accommodate as best we can; however, please feel free to bring supplemental foods to last throughout the week.

Other dietary restrictions: ______________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Food allergies: (please list along with reaction) _____________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Communication Skills**  (please check all that apply)

*Expressive Communication:*

___ Verbal, can be clearly understood  
___ Verbal, is difficult to understand  
___ Non-verbal  
___ Limited verbal vocab  
___ Uses gestures  
___ Uses Sign Language  
___ Uses communication device

*Receptive Communication:*

___ Can easily understand & follow directions  
___ Understands sign language  
___ Needs time to process & act on instructions  
___ Needs reminders & cues  
___ Cannot process/does not follow directions  
___ Other means of communication: ____________________________________________

Additional Comments: _________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Have there been any life changes you would like to share with us that may be helpful to ensure a successful camp session?** (i.e. new home, new school, marriage, divorce, death, health changes, etc.)
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
**Behavioral Information** (please check all that apply)

___ Has a behavior support plan *(please attach a copy)*

History of:

___ Verbal aggression

___ Physical aggression toward others
   ___ Biting
   ___ Hitting
   ___ Kicking
   ___ Other: _______________

___ Wandering/Running away from group

___ Self-injurious behaviors
   ___ Picking/Scratching
   ___ Head banging
   ___ PICA (please explain) ___________________________
   ___ Biting

___ Other behaviors to be noted: ________________________________

___ No behavioral issues

Please list any behaviors we may see at camp: __________________________________________
________________________________________
________________________________________

How often do behaviors occur? ______________________________________________________

What causes the behavior? (triggers): _______________________________________________

Recommended redirection techniques: ________________________________________________

Reminder: If camper requires 1:1 supervision in order to participate, for safety or behavior, *you must* provide an individual support person to attend with your camper.
Night Time Routine  (please check all that apply)
(Please note:  A minimum of two counselors sleep in the bunkhouse with campers.  There is no awake overnight staff.)

___ No concerns, sleeps through the night  
___ Wakes to toilet independently  
___ Wakes to toilet with assistance  
___ Wanders at night  
___ Wakes early; please note time: _____  
___ Requires medication to help sleep  
___ Requires bedrails  
___ Requires adjustment/repositioning at night, please describe: ______________________________

Additional comments: ________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Adjustment to Camp  (please circle one)

Has your child been to a summer camp (other than Camp CaPella) before? YES  NO  
If so, did he/she adjust well?  YES  NO  
Has your child ever been away from home before?  YES  NO  
Do you think he/she is likely to be homesick?  YES  NO  

If you think homesickness will be an issue, please give us some suggestions on how to best help your camper adjust. ___________________________________________________
________________________________________________________________________________
__________________________

Favorite camp activities: ____________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Least favorite camp activities: ________________________________________________________
________________________________________________________________________________

Swimming Level: please check one

___ Non-swimmer/does not like water  
___ Beginner  
___ Intermediate  
___ Advanced  

Swimming comments: ________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

9
# 2020 Summer Camp Schedule

**Overnight** Camp will run weekly from *Sunday* afternoon to *Friday*.

**Day** Camp will run weekly from *Monday* to *Friday*, 8:30am to 4:30pm.

*Please circle your choice and indicate your 1st and 2nd choice weeks, if applicable.*

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>OVERNIGHT CAMP</th>
<th>DAY CAMP</th>
<th>WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults*</td>
<td>June 24 to June 26*</td>
<td>June 24 to June 26*</td>
<td>1*</td>
</tr>
<tr>
<td>Adults</td>
<td>June 28 to July 3</td>
<td>June 29 to July 3</td>
<td>2</td>
</tr>
<tr>
<td>5-10 yo</td>
<td>July 5 to July 10</td>
<td>July 6 to July 10</td>
<td>3</td>
</tr>
<tr>
<td>10 - 12 yo</td>
<td>July 12 to July 17</td>
<td>July 13 to July 17</td>
<td>4</td>
</tr>
<tr>
<td>12-15 yo</td>
<td>July 19 to July 24</td>
<td>July 20 to July 24</td>
<td>5</td>
</tr>
<tr>
<td>15 - 18 yo</td>
<td>July 26 to July 31</td>
<td>July 27 to July 31</td>
<td>6</td>
</tr>
<tr>
<td>18-25 yo</td>
<td>Aug 2 to Aug 7</td>
<td>Aug 3 to Aug 7</td>
<td>7</td>
</tr>
<tr>
<td>Adults</td>
<td>Aug 9 to Aug 14</td>
<td>Aug 10 to Aug 14</td>
<td>8</td>
</tr>
</tbody>
</table>

*June 24 to June 26 is a special 3 day, camp option for adult campers who may benefit from a shorter camp experience.*

Overnight camp space is very limited. If full, would day camp be an option?  YES    NO

Did you attend Camp CaPella in 2019?  YES    NO    DAY    OVERNIGHT

Did you attend Camp CaPella prior to 2019?  YES    NO    If yes, when? _____________

## Travel Camp

Travel camp opportunities may include day trips, as well as, overnight retreats. Travel camp opportunities will be available in the Spring, Fall and Winter months. Previous travel camp options have included a Columbus Day Weekend Retreat to the Adaptive Outdoor Education Center, Winter Fun in Greenville, and more.

Would your camper be interested in Travel Camp options?  YES    NO
Camp Fees

The cost to attend one week of camp is $1500.00. It is our policy to never turn away a camper based on ability to pay. We do ask all of our campers to contribute a co-pay of $300. We understand that this may not be feasible for some of our campers and their families and any contribution you can afford will be greatly appreciated.

We are more than happy to make payment arrangements and offer suggestions to help you raise your camp fees.

Please let us know how much you anticipate to pay towards camp fees. Please check your answer.

I can pay the full price of $1500 _______ $1500 with payment arrangements _______

I can pay half at $750 _______ $750 with payment arrangements _______

I can pay the $300 co-pay _______ $300 co-pay w/ payment arrangements _______

I can pay a portion of my camp fees _______ Indicate how much you hope to pay _______

I will need to make payment arrangements _______

Additional comments: __________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Permission Forms:

**Photo Release:** Do you give Camp CaPella permission to video tape or photograph this camper while attending camp for 2019 for future promotional purposes?  YES  NO

Please Note: Photos taken are for Camp CaPella Use Only

**Field Trip Release:** Do you give permission for your camper to leave camp grounds for the purpose of a camp related field trip?  YES  NO

**Transportation Release:** Do you give permission for Camp CaPella staff to transport your camper for field trips, travel camp or emergency purposes?  YES  NO

**Medical Release:** In the case of emergency, I understand every effort will be made to contact me/the listed contact person. In the event I cannot be reached, I give permission to Camp CaPella to secure proper treatment, including hospitalization, necessary tests, anesthesia, surgery or injections of medication for me/this participant. Permission is given to transport me/this participant for medical assistance as deemed necessary by Camp CaPella staff. I understand I am responsible for payment of all medical treatments. The medical forms within this application may be photocopied for camp use.  YES  NO

**Immunizations:** Are there any immunization exemptions due to religious, medical or other reasons?  YES  NO

If yes, please explain: __________________________________________________________

*I understand and accept the risks of my camper not being fully immunized. I understand if there is an outbreak, I will be required to pick up my camper from the camp program.

____________________________________________________________________________  _________________

Parent/Guardian Signature  Date

I have reviewed this completed application. All information provided is correct to the best of my knowledge, and the participant herein described has permission to engage in all activities except as noted.

By signing below, I understand the guidelines as outlined within this application, and agree to follow them.

____________________________________________________________________________  _________________

Signature of Camper/Parent/Guardian  Date
Camp T-Shirt Order Form

It’s time to order your 2020 Camp CaPella T-Shirts!

Camp CaPella will provide 1 complimentary t-shirt for each camper. 
Please complete this form so your camper’s shirt will be available when they arrive at camp.

If you would like to order additional shirts, 
please return this form with $20.00 payment per additional shirt.

Camper Name: _______________________________________________________________

Size Needed: (please check one)

Child:   _____ Small   _____ Medium   _____ Large
Adult:   _____ Small   _____ Medium   _____ Large
                _____ XL    _____ XXL    _____ Other (please specify)

Order:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Cost</th>
<th>Total Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional T-Shirt(s)</td>
<td>_______ X</td>
<td>$20.00 each</td>
<td>$_______</td>
</tr>
</tbody>
</table>

Please indicate sizes above
Hang in there, you are almost finished!
The following four pages are required medical forms. They MUST be completed by your physician. Acceptance to camp cannot be determined until medical forms have been returned to camp.
Medical Information

The following 4 pages MUST be completed and signed by a physician. Acceptance to camp cannot be determined until all medical forms are returned.

Camper Name: ________________________________________________________________
Disability: ___________________________________________________________________
DOB: ____________________________________________  Male: _____  Female: ______
Physician Name: _______________________________________________________________
Address: _____________________________________________________________________
Phone Number: ____________________________

Allergies (please list allergy and reaction)

Medication Allergies: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Food Allergies: ________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Other Allergies: (hay fever, animals, insect bites or stings, etc.) __________________________
_____________________________________________________________________________
_____________________________________________________________________________

Seizures

Is this camper subject to seizures? YES  NO  If yes, please attach any special protocol.

Seizure Type: _______________________________  Frequency: _________________________
Seizure Triggers: ____________________________
How long do seizures last? __________________ Date of most recent: _________________

Notify parent/guardian: ___after every seizure ___ after seizure lasting ___ mins ___no notice

Return medical forms to:
Mail: Camp CaPella, PO Box 552, Holden, ME 04429-0552
Fax: 1-207-843-7413
Email: heidi@campcapella.org
Phone: 1-207-843-5104 with any questions and/or concerns
Health History (Please check all that apply)

- Heart Defect/Disease
- Diabetes
- Measles
- Hay Fever
- Hospitalization
- Mononucleosis
- Frequent Ear Infections
- High Blood Pressure
- Insect Stings
- Lyme Disease
- Chicken Pox
- Poison Ivy
- Asthma
- Mumps
- Other

Explain other: ________________________________________________________________

Medical conditions requiring notification of guardian and physician: ___________________
____________________________________________________________________________
____________________________________________________________________________

Operations or serious injuries or mental health concerns: _____________________________
____________________________________________________________________________
____________________________________________________________________________

Specialized Health Care Procedures

Does the camper require a specialized health care procedure while attending camp (i.e. nebulizer treatments, catheterization, etc.):   YES   NO  If yes, please complete the following:

Name of Procedure: ____________________________________________________________

Description of Procedure: Please include time intervals and conditions or symptoms that warrant repeating the procedure ______________________________________________________
_____________________________________________________________________________

List any precautions staff must be aware of before, during or after the procedure: __________
_____________________________________________________________________________

Mental Health Information

Is there a history of mental health issues?   YES   NO
Have there been any recent issues?   YES   NO   If yes, date of occurrence: _______________
Has there been any hospitalization, or stay at a mental health facility, due to mental health issues?   YES   NO   If yes, date of occurrence: _______________________
If yes to any of the above, please explain more._______________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Female Camper Information

Has this camper menstruated?   YES   NO
If not, has she been informed?   YES   NO
If yes, does she require assistance?   YES   NO
Additional comments: ____________________________________________________________
_____________________________________________________________________________
### Immunizations (you may attach immunization record in place of form)

<table>
<thead>
<tr>
<th></th>
<th>Year of Basic Immunization</th>
<th>Year of Last Booster</th>
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<tbody>
<tr>
<td>DTap</td>
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<tr>
<td>Tetanus</td>
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<tr>
<td>Polio (IPV)</td>
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<tr>
<td>MMR</td>
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<tr>
<td>Pneumococcal (PCV)</td>
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<tr>
<td>Haemophilus Influenza (HIB)</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Varicella (Chicken Pox)</td>
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<tr>
<td>Meningitis</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Are there any immunization exemptions due to religious, medical or other reasons?  Y   N
If yes, please explain: ________________________________________________________________

*I understand and accept the risks of my camper not being fully immunized. I understand if there is an outbreak, I will be required to pick up my camper from the camp program.

Parent/Guardian Signature ___________________________________________ Date

### Medication

*Please note - camper must be on a stable medication regime, and not in the process of changing medication or altering the dose of current medication, for at least one month prior to attending camp.*

___ This camper takes no medications on a routine basis.

___ This camper takes medications as listed below. Attach additional sheets if needed.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Time Given</th>
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<tbody>
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</table>
**Assistive Devices**

Eyes: Does camper wear glasses?  YES  NO  If yes, color of frame?  __________________________

Ears: Does camper wear hearing aids?  YES  NO  If yes, what support is needed?  __________________________

Orthotics: Does camper wear AFO or other braces?  YES  NO  
If yes, what support is needed?  ______________________________________________________

Other assistive devices used:  ______________________________________________________
____________________________________________________________________________

**Health Care Recommendations From Physician**

Blood Pressure ______  Weight ______  Height ______

In my opinion, this individual is capable of participating in camp activities except for the restrictions stated below.  YES  NO

Limitations or Restrictions:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Medical Concerns or Treatments to be monitored during camp:  __________________________
____________________________________________________________________________
____________________________________________________________________________

Date of Most Recent Physical:  ______________________________________

I certify that I have completed a physical of this person on the date listed above, which is within one year of the expected camp participation date. This person is in satisfactory condition to participate in an active summer camp program for and with people with disabilities. I am aware of all medications prescribed to this camper, as listed on the medication form, and see no contraindications.

Physician Signature  __________________________  Date

Physician Name and Title (Printed)

Address  __________________________  Phone
Before you submit your application, have you:

Read, understood and signed the camper eligibility form?  

Completed ALL sections of the application?  

Selected your preferred camp week?  

Completed the t-shirt order form?  

Medical forms are: (check one)

  Included  
  At doctor’s office  
  Will be sent by doctor  

Included application fee?  

Incomplete applications will not be processed until all required information is provided. Please do not omit information.