2012 RETREAT PROGRAM APPLICATION

Information provided is used by Woodlands staff for the purpose of summer and weekend retreat programming. All information is considered confidential. Please print in INK or type clearly. Complete the information in each section carefully and completely.

☐ **Check here if you are a NEW Woodlands participant.**
How did you hear about us? ☐ **From a current camper** ☐ **From a professional** ☐ **At an event** ☐ **Online** ☐ **Other**
Explain: ____

PARTICIPANT INFORMATION

Applicant's Last Name:____________________ First Name: ____________________ Middle:____________

Primary Diagnosis: ____________________________ Secondary: ____________________________

Date of Birth: _____/________/________ Age: ______________ Gender: ________________

Home Address (Street # or P.O. Box) ____

City, State, Zip ____________________________________ County: ________________________

Home Phone Number: ( ) ________________________

Adult Applicant's Email: ________________________ Adult Applicant's Cell Phone:( ) ____________________

Primary Care Physician: ________________________ Phone Number: ( ) ________________________

Secondary Physician: ________________________ Phone Number: ( ) ________________________

Primary Health Insurance/Carrier: ____________________ Phone Number: ( ) ______________ Policy # ____________

PARENT/GUARDIAN INFORMATION

	MOTHER	FATHER
Name:	______________ (Last) ______________ (First)	______________ (Last) ______________ (First)
Address:	______________ (Street)	______________ (Street)
Address:	______________ (City, State, Zip)	______________ (City, State, Zip)
Home Phone:	(_______)______________	(_______)______________
Cell Phone:	(_______)______________	(_______)______________
Employer:	______________	______________
Work Phone:	(_______)______________	(_______)______________

Email: ____

Marital Status of Parents: ___ Married ___ Separated ___ Divorced ___ Single Parent

*** If legal guardian, please attach documentation to establish basis of guardianship.**

☐ **Check here if the participant is their own legal guardian.**

MEDICAL CONDITIONS

Please check any medical conditions the applicant has and indicate the date of the problem and course of treatment.

☐ Asthma ____________________________	☐ Arthritis ____________________________	☐ Diabetes ____________________________
☐ Diarrhea ___________________________	☐ Growth Hormone Treatment ____________	☐ Heart Problems ______________________
☐ High Blood Pressure _________________	☐ Frequent Ear Infections ________________	☐ Frequent Skin Breakdown ______________
☐ Tubes in Ears _______________________	☐ Urinary Tract Infections ________________	☐ Insomnia/Sleep Disorder _______________
☐ Frequent Leg Fractures _______________	☐ Vision or Hearing Limitations ___________	☐ Hepatitis ____________________________
☐ Frequent Falls _______________________	☐ Seizures (see neurological history section)	☐ Other: ______________________________

____

____

NEUROLOGICAL HISTORY ☐ Yes ☐ No neurologic concerns

Level of lesion / injury? ☐ Cervical area (neck) ☐ Thoracic area (chest) ☐ Lumbar area (waist) ☐ Sacral area (below waist)

Does the participant have a shunt? ☐ Yes ☐ No

Where does the shunt start? ☐ Left side of head ☐ Right side of head ☐ Other ______________________________________

Where does the shunt end? ☐ Abdomen ☐ Heart ☐ Lung ☐ Other ____

Does the participant have a history of seizure? ☐ Yes ☐ No

Type of seizure/describe seizure activity ____

How often do seizures occur? ____ Typical length of seizure: _______________________________

Date of last seizure (as of current time of application): _________________________________

ALLERGIES

Does participant have a nut/peanut allergy? ☐ Yes ☐ No If yes, is it by consumption or airborne? ☐ Consumption ☐ Airborne

Please specify all other allergies. (For example: food, specific medicine, insects/bees, latex, animals, plants/pollen, materials, etc)

Specific Allergy	Reaction	Treatment

IMMUNIZATION HISTORY

	Date of Shot	Date(s) of Booster		Date of Shot	Date(s) of Booster
Measles			Tuberculin/TB		
Mumps			Diphtheria		
Rubella			Pertussis (whooping cough)		
Hepatitis B			Tetanus		
Chicken Pox			Other (specify)		

List and explain any hospitalizations and surgeries in the past year: (attach additional sheets if necessary):

MEDICATIONS

(M = Morning; N = Noon/Lunchtime; A = Afternoon; D = Dinner; E = Evening; B = Bedtime) **Times Taken**

Prescription & Non-Prescription	Purpose	Dosage (mg)	Form (Pill, liquid, chewable)	M	N	A	D	E	B	Special Instructions

Please provide any other pertinent information related to medication/administration:

____

____

PLEASE NOTE THE FOLLOWING:

- **Growth Hormone shots are not administered during weekend retreats.**
- **Medicines taken in pill form are to be pre-dosed and labeled in individual pill bags before arriving at camp .**
- **Pill bags are to be clear, sealable, and have a label to clearly write the day/time that specific med (s) are to be administered to the participant.**
- **For powder or liquid medications, bring this medication in original containers and also ensure there is enough medication to last the entire program duration.**

GENERAL URINARY BLADDER MANAGEMENT

How does the applicant empty his/her bladder?

□ Normal Bladder, no special program needed □ Catheterization (Size of Catheter ____)

□ Empties onto briefs or pads □ Other ____

How often is the bladder emptied? ____

Where is the routine performed (on the toilet, from the applicant's wheelchair, lying down)? ____

In general, is the applicant wet between the times in which he/she empties his/her bladder? □ Yes □ No

Does the applicant consistently remember when to perform his/her bladder routine? □ Yes □ No

Describe the applicant's need for assistance with his/her bladder routine: ____

____

Does the applicant irrigate his/her bladder? □ Yes □ No How often? ____

Supplies used: ____

Describe assistance needed: ____

List the applicant's most common symptoms which indicate a urinary tract infection: ____

____

If applicant has a urinary diversion (loop), how long does the appliance stay on? ____

GENERAL BOWEL MANAGEMENT

How does the participant empty his/her bowels? □ Normal Bowel movements, no special program needed □ Empties into briefs

□ Uses enema □ Uses ostomy bag Other details: ____

Describe frequency of bowel emptying/care on typical day? ____

PLEASE NOTE THE FOLLOWING:

- **BE SURE TO BRING ENOUGH BOWEL AND/OR BLADDER SUPPLIES FOR THE ENTIRE SESSION.**
- **IF APPLICANT USES A NIGHT DRAINAGE BAG, BE SURE TO PACK IT.**
- **ENEMAS WILL NOT BE GIVEN ON "WEEKEND" RETREATS. PLEASE ADJUST YOUR BOWEL MANAGEMENT SCHEDULE TO ADDRESS THIS BEFORE ARRIVING TO WOODLANDS.**

Additional Parent/Caregiver comments:

DIETARY NEEDS

Please explain any special diet needs or restrictions while at camp (ex. low sodium, caffeine-free, gluten free, etc.). Include food product transfusions, special handling, and pre-medications. ____

____

Please list any assistance which the applicant requires at mealtimes (i.e. cutting food, portioning food): ______________________

____

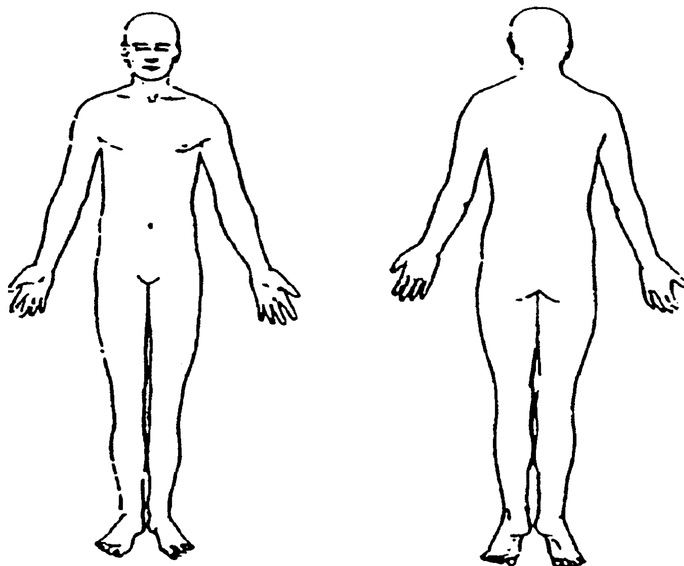
Favorite Foods: ______________________ Least Favorite Foods: ______________________

Does the applicant have trouble with chewing, swallowing or gagging? □ Yes □ No

If yes, please describe: ____

SKIN CARE

Using the picture to the right, please circle areas in which applicant has a current skin breakdown and mark an “X” on areas which are sensitive or at risk to skin breakdown.



Describe any needs for skin care assistance:

____

____

____

____

____

____

Current Breakdown Area	Type of Dressing	Time of day to change dressing

PLEASE BRING ENOUGH DRESSING SUPPLIES FOR THE DURATION OF THE SESSION.

TRANSFERS / ADLs (activities of daily living)

☐ Applicant is independent in performing all their own personal care.

Check each activity where the applicant needs assistance to perform the task. Describe the type of assistance needed.

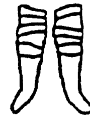
	DESCRIBE ASSISTANCE NEEDED
TRANSFERS TO AND FROM	
☐ Bed	
☐ Toilet	
☐ Shower chair	
☐ Car / Van	
ADLs / SELF CARE	
☐ Showering	
☐ Washing hair	
☐ Combing hair	
☐ Shaving	
☐ Brushing teeth	
☐ Dressing self	
☐ Menstrual Needs	
☐ Organizing belongings	
☐ Making bed	

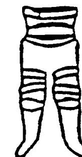
BRACES

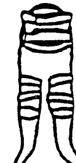
Does the applicant wear a brace? ☐ Yes ☐ No

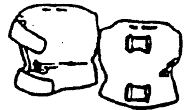
Circle (or specify) the type of bracing used:

____









Type of assistance needed putting on or taking off his/her braces: ____

Can applicant instruct someone to assist with putting on and taking off his/her bracing? ☐ Yes ☐ No

How many hours should braces be worn? ____

MOBILITY

Please describe how the applicant gets around **(Check all that apply):**

For safety reasons, please bring all personal mobility equipment to camp. <u>Please be sure all mobility equipment is in working order before camp.</u> Wheelchairs should have working seat belt, brakes, anti-tippers, and adequate tread on the tires. <u>Please contact your supplier if any items are not in working order to have such repaired prior to arriving at the Woodlands.</u>

☐ No device needed	☐ Completely independent , no assistance or device is needed
☐ Manual Wheelchair ☐ Power Chair Type of cushion: ____________	☐ Independent when using mobility device
Hours spent in wheelchair :	☐ Close supervision while using mobility device
☐ All day	☐ Needs physical assistance from others
☐ "Some" of the day: ______ hours walking	☐ Needs verbal prompting from others
☐ Walker ☐ Cane ☐ Crutches ☐ Braces / Prostheses ☐ Other – specify:	Does the applicant have a history of frequent falls? ☐ Yes ☐ No If yes, please provide reason:

PSYCHO-SOCIAL ISSUES *Information will remain confidential among staff working with the applicant.*

Does applicant have any specific fears or anxieties (ex. darkness, dogs, bugs, loud noises, etc.)? ____

____

Please share the applicant's history with the following:
RELATING TO PEERS

- ☐ No problem
- ☐ Current problem, but does not interfere with everyday functioning
- ☐ Problem, interferes with everyday functioning
- ☐ Severe problem that requires intervention

Please describe: ____

AGITATION

- ☐ No problem
- ☐ Current problem, but does not interfere with everyday functioning
- ☐ Problem, interferes with everyday functioning
- ☐ Severe problem that requires intervention

Describe problem: ____

AGGRESSION

- ☐ No problem
- ☐ Current problem, but does not interfere with everyday functioning
- ☐ Problem, interferes with everyday functioning
- ☐ Severe problem that requires intervention

Describe problem and how aggression is demonstrated:____

____

INAPPRORIATE or UNUSUAL BEHAVIORS

- ☐ No such behavior is exhibited
- ☐ Current problem, but does not interfere with everyday functioning
- ☐ Problem, interferes with everyday functioning
- ☐ Severe problem that requires intervention

Describe behavior(s): ____

____

Indicate behavior management techniques that are effective: ____

____

Is the applicant currently receiving any form of counseling? ☐ Yes ☐ No If yes, for what issues? ______________________________

____

Describe any other issues that staff need to be aware of in order for the applicant to enjoy and safely particpate in the program.

____

____

COMMUNITY SUPPORT AGENCIES / WAIVERS

Does the applicant have an open case with the **Office of Mental Health / Mental Retardation** (MHMR) or other third party agengy? ☐ Yes ☐ No

Any other third party support agency? ☐ Yes ☐ No

If yes to either of the above, provide Caseworker's Name: ____

Agency :____ Phone: ____________________________________

On behalf of the applicant, may Woodlands request program funding from these community agencies to support the cost of program? ☐ Yes ☐ No

If not currently receiving support, or if unaware how to obtain support, would you like Woodlands to send you information? ☐ Yes ☐ No

EDUCATION

Name of the school where the applicant currently attends: ____

Current Grade Level: ______________________ Does applicant currently need learning support? ☐ Yes ☐ No

If yes, please explain type of support:____

____

School Address: ____

County of School District: ____

RECREATION & LEISURE

What level swimmer is the applicant? ☐ Advanced ☐ Intermediate ☐ Beginner ☐ Cannot Swim ☐ Wants to Learn

What hobbies does the applicant enjoy and excel in? ____

____

If given the opportunity, what is the one recreational activity the applicant wishes they could participate in? ______________________

Overall, the applicant's leisure activities would best be described as (please check only one):

☐ Mostly active recreation (Frequently involved in outdoors, sports, fitness/exercise, extra curricular school activities)

☐ Mostly sedentary/passive activities (Excessively engaged in TV, movies, computer, video games, reading, board games)

☐ A mixture of both active recreation and sedentary/passive leisure.

PARENT / CAREGIVER GOAL

What goal (s) do you have as a parent/caregiver as you anticipate your loved one's participation in Woodlands camps and/or weekend retreats?

1) ____

2) ____

PARTICIPANT GOAL

If able to share, what goal (s) does the participant themself have while engaged in Woodlands camps and/or weekend retreats?

1) ____

2) ____

To the best of my knowledge all completed information given on this application is current and correct.

____

Signature of Parent/Guardian/ Participant (if Adult age) **Date**

EQUAL OPPORTUNITY AGENCY

The Woodlands Foundation, Inc. is an equal opportunity agency. Services are provided to individuals with disabilities regardless of race, creed, color, gender, national origin or marital status. Since participant safety and health are a top priority, WFI reserves the right to deny program participation to anyone whose health care or physical needs are beyond the scope of staff competency and/or specific program objectives/requirements.

The Woodlands is proud to be recognized as an American Camp Association (ACA) accredited program site.