



Please return completed applications to us by:

- Email: cfreeman@thebridgesfound.org
- Fax: 918-299-2146
- Mail: The Bridges Foundation
Attn: Camp
1813 N. Ash St. Jenks,
OK 74037

Registration Application

This application is meant to assist The Bridges Foundation in creating the best possible experience for campers with special needs. Please complete the sections as they apply to your child. Thank you!

Camp fees are \$175 a week, scholarships are available on a first come, first serve basis. Fees are due at the beginning of each week.

Camper name: _____

Address: _____

City: _____ State: _____ ZIP _____ Phone: _____

Age: _____ Date of birth: _____ Male: _____ Female: _____

Parent or guardian: _____

Email: _____ Camper's shirt size: _____
& shoe size _____

Health insurance information:

Carrier: _____ Group number _____ ID number _____

Name of primary insured: _____

Relationship to camper: _____

Primary care doctor: _____

Phone: _____ Date of last examination: _____

Emergency contacts:

** Please list someone other than the parent/guardian listed above, and someone who will know how to contact you if we are unable to reach you.*

Name: _____ Phone: _____

Relationship to camper: _____

Name: _____ Phone: _____

Relationship to camper: _____

Camp sessions: Please mark all the sessions your camper is available to attend, and we will do our best to place them in the most appropriate group of campers:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> June 13- June 16 | <input type="checkbox"/> June 20- June 23 | <input type="checkbox"/> June 27- June 30 | <input type="checkbox"/> July 11- July 14 |
| <input type="checkbox"/> July 18- July 21 | <input type="checkbox"/> July 25- July 28 | <input type="checkbox"/> No camp July 4-8 | |

Documentation to be submitted with application: psych evaluation, photo of the camper

Camper's diagnosis: (Check all that may apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Autism | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes: Type I or II | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Asperger's | <input type="checkbox"/> Blind | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Communication delay | <input type="checkbox"/> Obesity | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Spinal cord injury: Quadriplegic or paraplegic | | | |

Breathing difficulties:

*Trach: Specify type _____

*Any important surgeries, hospitalizations or medical complications that may affect the child's camp experience? _____

Medical information:

Vision

- | | | |
|--|--|--|
| <input type="checkbox"/> Sighted/ Normal | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Legally blind |
| <input type="checkbox"/> Partially sighted | <input type="checkbox"/> Color blind | <input type="checkbox"/> Other: _____ |

Hearing

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Partial hearing | <input type="checkbox"/> Legally deaf |
| <input type="checkbox"/> Normal with aid | <input type="checkbox"/> Partial hearing with aid | <input type="checkbox"/> Other _____ |

Communication

Is the camper able to understand and communicate his/her needs to others? (Ex. Food, drink, bathroom, help) Yes No

- | | | | |
|-------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Communication board | <input type="checkbox"/> PECS | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> Non-verbal | <input type="checkbox"/> Electronic device | <input type="checkbox"/> Sign language | <input type="checkbox"/> Other |

If other, please explain: _____

Mobility

- | | | |
|---|--|---|
| <input type="checkbox"/> Ambulatory (no assist) | <input type="checkbox"/> Wheelchair- power | <input type="checkbox"/> Wheelchair- manual |
| <input type="checkbox"/> Cane(s) | <input type="checkbox"/> Walker | |

Behavior:

General disposition: (Check all that may apply)

- Generally easygoing Unsure of new situations Wanders
- Temper tantrums Shy/withdrawn Helpful

Is this your child's first time staying away from home? _____

What does your child like? What is he/she afraid of? _____

In your opinion, what is your child's developmental age? _____

Please indicate how often your camper exhibits the following behaviors and the consequences:

Behavior	How many times does behavior occur? Daily or monthly?	What causes behavior?	How do you address this behavior?
Scratches, pinches or hits self or others			
Bangs head			
Grabs others			
Touches others inappropriately			
Throws things			
Gets into personal belongings			
Runs away			
Climbs on furniture			
Uses inappropriate language			
Spits on others			
Dumps food or liquids			
Strips clothing			
Other			

Personal care information:

Eating

- No Assist Partial assist Total assist

Please describe any assistance required for feeding: _____

List adaptive equipment needed for feeding: _____

Diet

- Normal Chopped food Blended/ puree Diabetic
 G-Tube only G-Tube and oral foods

Food allergies or special dietary needs: _____

Does the camper have any difficulty swallowing? Yes No

List any strongly liked or disliked foods: _____

Toileting

- Bladder control: No assist Needs reminder Occasional accidents
 Incontinent Total assist
- Bowel control: No assist Partial assist Total assist

Please explain home toileting routine: _____

Does your child wear:

- Underwear Pull-ups Diapers
 Other: _____

Bathroom aids:

- Urinal Toilet chair Catheter Other: _____

Dressing

No assist Partial assist Total assist

Please describe dressing routine: _____

Medication information:

Does the camper have any allergies? Medication Food Other

If yes, please list: _____

Does the camper take any medication? Yes No

If yes, please list: _____

Consent:

This health history is correct as far as I know. My child has my permission to engage in all camp activities, including horseback riding, unless exceptions noted:

I give my permission for medications to be administered by a MAT certified staff member and understand that WRITTEN INSTRUCTIONS ARE REQUIRED. This includes prescription and non-prescription drugs, as well as topical or external applications. Medications are to be labeled and given to the nurse at the start of camp; no medications can be left with your child for self-medication.

In the event of injury, I hereby give permission to the medical personnel selected by the camp staff to order X-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for my child.

Signature of Parent/ Guardian _____

Date _____

