

OFFICE USE ONLY

Received: _____ Reservation: _____ Session: _____ Completed by: _____
Complete: Yes No Confirmation: _____ Dorm: _____
Returned: _____

Follow-up: _____

Concerns: _____



Lions Camp Tatiyee, Inc.

Send completed applications to:
P.O. Box 6910 • Mesa, AZ 85216

After May 20th, Send to: 5283 White Mountain Blvd.,
Lakeside, Az 85929



Camper Application

Lions Camp Tatiyee operates on a first-come, first-serve basis, beginning January 2nd of each year.

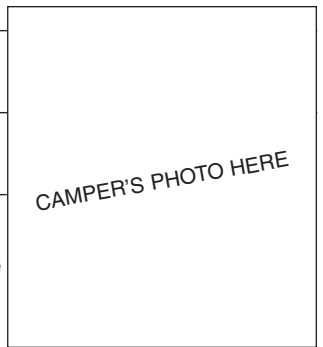
All pages must be completed or the application will not be considered.

Camper's Full Name: _____
LAST FIRST MIDDLE

Parent(s) Guardian(s) Name: _____
LAST FIRST MIDDLE

Address: _____
STREET OR BOX CITY AND STATE ZIP CODE PARISH

Camper's age: _____ Date of Birth: _____ Gender: Male Female



CONTACT INFORMATION

Parent or Guardian Home Phone: _____ Work Phone 1: _____ Work Phone 2: _____

Cellular Phone _____ E-mail Address _____

1st Emergency Contact Name _____ Phone # _____ Relation _____

2nd Emergency Contact Name _____ Phone # _____ Relation _____

*** If you do not have a phone, please list a friend, neighbor, or relative so that we can contact you while your child is at camp in the event of a problem or emergency.

Has camper spent a week away from a parent before? Yes No Comments _____

Has camper attended any other camp before? Yes No

If yes, where? _____ When? _____

Has camper been to Lions Camp before? Yes No If yes, when (list most recent date)? _____

My camper attends: (check one) Regular Education Special Education Self-Contained Class Inclusion

How did you find out about Camp Tatiyee? _____

**The information you provide on this application helps us in caring for your camper.
Deaf Session applicants - skip this page**

Primary Disability: _____

Secondary Disability: _____

Mark the ones that apply: 1 = Always 2 = Sometimes 3 = Never

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Body Brace | <input type="checkbox"/> AFO's |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Crutches | <input type="checkbox"/> Helmet |
| <input type="checkbox"/> Communication Board/Device | <input type="checkbox"/> Walker | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Cane | <input type="checkbox"/> Other: _____ |

Check the one that applies: I = Independent A = Assisted TC = Total Care

DRESSING I A TC

Comments: _____

FEEDING I A TC

Special Utensils: Yes No

With Utensils I A TC

Basic Dietary restrictions? (food allergies, blending required, etc. ... Lions Camp Tatiyee does not specialize meals)

BATHING I A TC

Brushing Teeth I A TC

Brushing Hair I A TC

Comments: _____

TOILETING I A TC

Diapers I A TC

Catheter I A TC

Self-Cath I A TC

How much supervision is necessary if camper self-caths? Please explain: _____

Self Toileting I A TC

Bed Wetting Yes No

Comments: _____

Communication

- Limited But Can Communicate Needs
- Non-Verbal
- Communication Device
- No Problems
- Sign Language

Follows Direction

- Can follow verbal directions
- Can follow directions with gestures
- Needs repeated directions
- Can follow a one-step direction
- Can follow a two-step direction

Groups

- Will stay with group
 - Wanders off
 - Will run away at times
- Possible Triggers?*

Social/Behavior

My camper behaves as a _____ year old.

Possible problematic behavior: _____

What do you do at home for this? _____

Tell us what attribute you enjoy most about your child? _____

What do you hope for your child to get from this experience? _____

What techniques motivate your child to respond positively when redirected? _____

What comforts your child? _____

☆☆☆☆Must be completed and returned with application☆☆☆☆

Consent Form - Parent or Guardian must initial each statement before a child can attend camp.

This form must be completed and returned with your child's application. Parent or Legal Guardian must read and initial each statement.

Camper's Name: _____

- _____ The Camp may publish my child's name and address in its weekly camper memory booklet.
- _____ I hereby give consent for said camper to participate in the Arizona Lions Camp Tatiyee.
- _____ I will be available by telephone for the first 24 hours that my child is at camp. I have listed the names of at least two people who should be contacted in the event that I cannot be reached during an emergency. I have notified these people that they may be contacted and will make sure that in the event that I am not going to be able to be reached at any point during the camping sessions, that at least one of these two people will be accessible. The camp has my permission to release my camper to them.
- _____ I acknowledge and will recognize the Camp's right to send home any camper if illness or other reasons deem it necessary, including behavioral problems.
- _____ I understand that if my child becomes violent or is a threat to his/her own safety or to the safety of others, the Camp may release him/her to appropriate agencies (CPS, law enforcement or mental health).
- _____ I understand that all campers will receive a health screening before being allowed to check in to camp and that they must be free of contagious conditions (fever, head lice, etc.) before being admitted.
- _____ I hereby grant permission to the Camp's Director, Nurse, or their authorized representatives to furnish or arrange for the pre-hospital and hospital/medical care that the camper might require during such time as the camper is a resident at Arizona Lions Camp Tatiyee.
- _____ I have fully disclosed all of _____'s health conditions, including any propensities towards violent behavior. I authorize Lions Camp Tatiyee to share this information with their counseling staff.

I am therefore authorizing:

Physicians, nurses, hospitals and their authorized personnel employed, contracted or paid on a fee basis by the Camp to perform all treatments and procedures deemed necessary; and

Release of medical/hospital records to the Camp from existing medical/hospital records; and

Release of hospital/medical records from the Camp to Physicians, Nurses, Hospitals and their authorized personnel for the performance of treatments and procedures as deemed necessary.

_____ The Parents/Guardian and/or their health insurance provider are responsible for all medical bills incurred by above camper.
Is the camper covered by family medical/hospital insurance? Yes No

Carrier or Plan Name _____ **Group Number** _____

Name of Insured _____ **Social Security # of Policy Holder** _____

- _____ All medications and prescriptions to be administered will be surrendered to the Camp Nurse upon arrival at Camp; dispensing thereof will be derived from the medical statements on the application. Medications will be dispensed according to the prescription written on the bottles or containers.
- _____ I grant permission for photographs and videos to be made of my child by Camp personnel during the camping session for use in Camp publicity which includes brochures, pamphlets, posters, internet, or other public relations that is in the proper interests of the Camp and is approved by the Camp. The Camp is not responsible for photos or videos taken by other campers.
- _____ I acknowledge the Camp's right to search campers' possessions.
- _____ I understand that visitations and phone calls from family/friends are not part of the program and though accepted in emergencies, must be arranged through the Camp's director.
- _____ The camp is not responsible for personal items lost, damaged, misplaced or stolen.

If needed, please complete: For religious or other reasons, my child may not participate in the following activities:

Parent/Legal Guardian Signature _____ Date _____

Waiver of Responsibilities

The undersigned do(es) hereby release and discharge CAMP TATIYEE, INC., and any and all of its agents or affiliates, employees or servants from any and all claims, liabilities, demands or rights which I (we) , or any friends or relatives, may have against said corporation, or any of its agents, affiliates, employees or servants on account of, connected with, or growing out of, any injury, accident, loss, damage or suffering, I (we) may hereafter sustain while on the premises or property owned, leased or used by CAMP TATIYEE, INC., arising out of the granting of permission for a camping experience or usage of the said premises, whether said property be known as CAMP TATIYEE, INC., or any other named designation or location.

I have read, or have had read to us, the foregoing and do hereby acknowledge that I fully understand each and every part thereof.

Dated this _____ day of _____, 20_____

Witness: _____

Signature of Applicant (if adult): _____

or Signature of Guardian (if minor): _____

or Guardian Signature for Adult: _____

*** COMPLETED BY PHYSICIAN ONLY ***
LIONS CAMP TATIYEE *MEDICAL REVIEW*

Please print legibly and complete the entire form.

Applicant's Name: _____ Date of Exam: _____
Date of Birth: _____ Gender: _____ Height: _____ Weight _____
Primary Disability: _____

Secondary Disabilities: _____

If mentally challenged, give functioning age: _____ **Are immunizations current?** Yes No

Previous illness, conditions or characteristics? Check all that apply:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Aggression* | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Heart Disease/Condition | <input type="checkbox"/> Stroke: When? _____ | Special Issues _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer: Remission? _____ | Noise Issues _____ |
| <input type="checkbox"/> Seizure Type: _____ | <input type="checkbox"/> Communicable Disease* | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Frequency: _____ Duration: _____ | <input type="checkbox"/> Other Psych. Disorder. | <input type="checkbox"/> ADD / ADHD |

*Please explain: _____

Any recent, serious medical illness or surgery? _____

Any recent minor illness/ailment? _____

Allergies/Sensitives (including medications): _____

Seizure History (if applicable)

Type? _____

What may bring them on? _____

Does the camper have any warning that a seizure is on-coming? _____

How long do they last? _____

How does the camper typically act after a seizure? _____

Any special needs after a seizure? _____

Specifically when was the last petit mal/complex? Date: _____

Specifically when was the last grand mal/complex? Date: _____

Comments: _____

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the camper's life? Yes No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Hearing: Right ear: _____ db Left ear: _____ db

Vision: Totally Blind Legally Blind (20/200 or sidevision) Low vision (vision of 20/40 or less)

Neuromuscular:

1) Paralysis or loss of muscle function in:

a) Upper Extremities: Due to a stroke? Yes No

b) Lower Extremities: Due to a stroke? Yes No

2) Convulsive or neuro-motor seizures:

a) Type: _____ b) Frequency: _____

c) Duration: _____ d) Last Occurrence: _____

Other Evidence of Pathology:

1) Cardiovascular: Abnormal rhythm? _____ Pacemaker? Yes No

2) Pulmonary: _____

Treatment? _____

3) Other: _____

Is applicant cleared for 7,000 feet elevation? Yes No

Activity Level Advised?

I approve supervised camping activities, including participation in arts and crafts, Go-Karts, recreation, overnight campouts, and swimming. Non-strenuous Minimum Moderate Full

*If not full activity level or excluding activities stated above, please explain: _____

Was the exam completed by a personal physician or specialist? Yes No

Physician's Name: _____ Date of Exam _____

Signature: _____

Street Address: _____

City, State, Zip: _____

Day Phone: (_____) _____ Emergency Phone: (_____) _____

Off-Season: P.O. Box 6910 • Mesa, AZ 85216 • (480) 380-4254
Seasonal: 5283 White Mountain Blvd., Lakeside, AZ 85929
E-mail: arizonalionscamp@cox.net • www.ArizonaLionsCamp.org

Please attach medical sheet with Doctor's Signature or use form provided.

List all prescribed medications or attach list signed by Physician. Vitamins will **NOT** be accepted.

MEDICATIONS Please provide all information about each medication, follow example below:

Medication (mg)	Amount Given	Times Given	Special Instructions

Doctor's Signature: _____

Date: _____

Contact Info: _____

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