



SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, Inc.

4283 Paradise Road • Seville, Ohio 44273 • Telephone: 330-722-1900; 330-336-2045; 330-225-4202
Fax: 330-723-6695 • www.shc-medina.org

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January 14, 2010

Dear Friends,

SHC/The Arc is offering a Kids Concoctions Respite Camp for school age youth on Saturday, February 20, 2010, 9:00 a.m. to 9:00 p.m. The fee is \$80 for the full day. The option of an hourly rate is available; call for details.

The day will be filled with opportunities for campers to explore their creative talents as a "chef." Campers should bring their bathing suit if they want to participate in the swim session; towels will be provided.

If your camper did not attend a summer camp or respite session at Camp Paradise in 2009, the Medical Record Form will need to be completed by a physician. Unless you indicate otherwise, we will use the current medical information on file dated 2009 for repeat campers.

Please review the enclosed packet *carefully* and note the deadlines. Please give detailed information regarding your camper's needs. This will help us provide a safe and fun-filled camping experience for everyone. Applications submitted before **February 15, 2010** will be accepted on a first-come basis. **We are limited to 24 campers**, therefore, any application submitted after **February 15, 2010** will be subject to a **\$25.00** late fee, and will only be accepted if there is an appropriate available open slot. SHC now accepts credit cards to pay camp fees. Call the SHC office, **ext. 235**, for more information. **DO NOT PROVIDE YOUR CREDIT CARD NUMBERS ON APPLICATION FORMS.**

You may be eligible for Family Resource or waiver funding for respite. Contact the Service and Support Administration offices (330-764-8988) of the Medina County Board of DD for information.

Important Medication Instructions: Please bring all medications in their original prescription bottle. Medications will be administered by trained staff. If camper is exposed to any communicable disease during the two weeks prior to respite camp, please notify us.

All belongings should be clearly labeled with name of camper. Campers should not bring money or other valuables. We do our best to ensure all articles are returned, but we cannot take responsibility for the loss of property.

Checklist of items due by February 15, 2010:

- Kids Concoction Respite Camp Registration Form
- \$25.00 Non-Refundable Deposit
- Medical Record Form completed by Physician
- PRN Form completed by Parent or Physician
- Parent/Guardian/Camper Consent Form
- Activities of Daily Living Form

Your camper's participation will be confirmed by phone no later than February 16, 2010. We hope this day of respite will provide an opportunity to do holiday errands or to spend a relaxing day at home!

Cordially yours,

Sharon Biggins,
Camp Paradise Director

Enclosures



The SHC is The Arc of Medina County
Assisting Citizens with Disabilities



Kids Concoctions Respite Camp Registration - Continued

Camper's Name: _____

Please describe camper's disability/special needs: _____

ALLERGIES Please list all known allergies of participant:

Medication Allergies:	Please describe reaction and management of the reaction:
Food Allergies:	
Other Allergies:	

Does Camper:

- Yes No Have an IEP, IP (Individual Plan), or Behavior Plan? If yes, **please include a copy of the Plan.**
- Yes No Require communication assistance? List: _____
- Yes No Have any special behavioral considerations (i.e. temperature, storms, bugs, etc.)? List: _____
- Yes No Have any special considerations that would help make this a good experience (i.e. special phone calls, etc.)? List: _____

*****If yes to any of the above questions please explain in the space provided below*****

Explanations to enhance this camper's experience from above: _____

List some activities the camper enjoys, additional comments or suggestions: _____

RESPITE CAMP MEDICAL RECORD
THIS IS A REQUIRED FORM – DUE FEBRUARY 15, 2010
TO BE COMPLETED BY A PHYSICIAN

**A COMPLETED FORM IS REQUIRED FOR ALL CAMPERS UNLESS
THE CAMPER ATTENDED A SUMMER OR RESPITE SESSION AT CAMP PARADISE IN 2009.**

Did camper attend a summer or respite session at Camp Paradise in 2009? Yes No (If No, form must be completed)

If YES, is the information on the Medical Record form from 2009 still current? Yes No (If No, form must be completed)

If the camper is taking prescription medication an exam must be performed within 6 months of arrival at camp. If the camper does not take medication this exam should be performed within 12 months of arrival at camp. We will also accept a copy of another examination signed by camper's doctor if within these time frames.

PLEASE PRINT CAREFULLY:

Camper's Name: _____

Date of Birth: _____ Age: _____

Please list **Allergies** if any: _____

Parent/Guardian: _____ Phone: _____

PHYSICIAN STATEMENT – Must be filled out by a Physician

_____ (Camper's Name) **(IS) (IS NOT)** TAKING MEDICATION AT THIS TIME.
(please circle one)

TETANUS SHOT CURRENT (WITHIN LAST 10 YEARS): YES _____ NO _____

ANY CHANGES IN MEDICATION AFTER FEBRUARY 15, 2010 WILL NEED TO BE SUBMITTED ON A PHYSICIAN SIGNED ADDENDUM PRIOR TO STARTING CAMP. IF CAMPER IS ON MEDICATION COMPLETE THE FOLLOWING:

Name of Physician prescribing medication: _____ Phone: _____
(Please Print)

Camper is to take Medications while at Respite Camp as follows:

Name of Medication	Dosage and Frequency	Method of Dispensing (crushed, whole or in applesauce)

Medical Diagnosis: _____

Please list all health concerns which should be known by camp staff:

I certify the above applicant is fit to participate in the Respite Camp program and is free of communicable disease:

Physician Signature: _____ Date: _____

APPROVED PRN MEDICATIONS FOR YOUTH CAMPER

TO BE COMPLETED AND SIGNED BY A PHYSICIAN, PARENT, OR GUARDIAN

THIS IS A REQUIRED FORM FOR THE RESPITE CAMP PROGRAM - **DUE FEBRUARY 15, 2010**

Camper's Name: _____ Date: _____

Allergies: _____

The following are approved PRN medications, which may be utilized for common ailments unless contraindicated:

Symptom	Medication	Dosage
Headache, Pain, Fever	Acetaminophen	Per product recommendation based on camper's age and weight.
Muscle Aches, Menstrual Cramps	Ibuprofen	Per product recommendation based on camper's age and weight.
Nasal Congestion	Sudafed	Per product recommendation based on camper's age and weight.
Sore Throat	Chloraseptic	Per product recommendation based on camper's age and weight.
Stomach Ache, Indigestion	Riopan Plus	Per product recommendation based on camper's age and weight.
Sun Protection	SunBlock SPF #30	Topically to exposed areas as needed
Sunburn	Americaine Spray	Topically to affected areas as needed
Dry Skin	Moisturizing Lotion	Topically to affected areas as needed
Cuts, Abrasions	Hydrogen Peroxide Bacitracin Ointment	Topically to open area 1 – 3 times daily as needed Topically to open area 1 – 3 times daily as needed
Rash, Insect Bites, Itching	Benadryl and/or Caladryl Lotion	Per product recommendation based on camper's age and weight.

Physician Signature: _____ Date: _____

OR

Parent or Guardian Signature: _____ Date: _____

RESPITE CAMP

CONSENT FORM / AUTHORIZATION FOR PICK UP
DUE FEBRUARY 15, 2010

CONSENT

Camper's Name: _____

Yes No **I hereby** authorize Camp Paradise Respite Camp to act for me accordingly using their best judgment and ability in any emergency requiring medical or surgical care.

Name of Family Doctor: _____ **If necessary, may SHC staff call another doctor or take camper to the hospital? Write "YES" or "NO":** _____

Yes No **I give** permission for _____ to participate in:
(Camper's Name)
a supervised swimming program during Respite Camp which may include time in the hot tub (no more than 15 minute sessions); and,

Yes No **To be** photographed while engaging in activities involving Respite Camp. I also consent to the public dissemination of this material for educational and promotional purposes.

Parent/Guardian Signature: _____ Date: _____

Camper's Signature: _____ Date: _____

AUTHORIZATION FOR PICK UP

Please be advised that for the safety of all campers, only persons listed on this form will be able to pick up your camper. You may be asked to provide identification at the time of pick up.

The following individuals are authorized to pick up my camper:

Signature – Parent or Guardian Date

ACTIVITIES OF DAILY LIVING FORM - DUE FEBRUARY 15, 2010

CAMPER'S NAME: _____ **DATE:** _____

Please be as specific as possible:

EATING/DRINKING:

- Independent
- Difficulty swallowing
- Needs food cut up and special plate or utensil (list) _____
- Must be fed
- Can use straw

Explain: _____

DIET:

- Normal
- Low salt
- Low calorie – Total calories _____
- Diabetic – Total calories _____
- Knows limits
- Chopped food
- Blended/pureed food

List food restrictions: _____

List food allergies: _____

SWIMMING:

- Requires Life Jacket or Floatation Device

MOBILITY:

- Walks independently
- Walks: Needs assist w/ slopes, rough areas
- Wheelchair: Independent
- Wheelchair: Assist w/ slopes, rough areas
- Wheelchair: Needs assist at all times
- Wheelchair: Long distances only
- Requires rest during the day

TRANSFERS:

- Camper weighs: _____ lbs.
- Can make independently
- Pivot transfers/can bear weight on feet
- Must be lifted *

Please explain: _____

* must provide own hooyer, if needed.

DRESSES/UNDRESSES:

- Independent
- Needs partial assistance
- Needs total assistance

Explain: _____

BATHING:

- Independent
- Needs partial assistance
- Needs total assistance
- Uses shower
- Uses shower chair

Explain: _____

BATHROOM:

- Independent
- Bladder incontinence
- Bowel incontinence
- Requires prompting for toileting
- Needs transfer to toilet
- Needs assistance wiping
- Needs total assistance
- Uses toilet chair
- Uses urinal
- Uses special undergarments
- Requires assistance with menstrual care

ADAPTIVE EQUIPMENT:

- Glasses
- Contacts
- Hearing Aid
- Dentures
- Other (list) _____

Please explain other personal care needs:

