

# Easterseals Tennessee Youth Camp Registration 2024

Camper Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_\_\_ Age at camp: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home/Work/Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## TRANSPORTATION

**\*\*\* UNFORTUNATELY, YMCA CAMP WIDJIWAGAN NO LONGER OFFERS  
BUS TRANSPORTATION FOR OUTSIDE AGENCIES. PLEASE DRIVE YOUR CAMPER  
TO THE DEDICATED SPOT BELOW. EASTERSEALS IS WORKING ON A PLAN TO  
RESOLVE THIS ISSUE FOR FUTURE SUMMER CAMPS. \*\*\***

Follow signs to Pick-Up and Drop-Off campers at Clark Baker Lodge

Drop off: 7:30am - 8:30am

Pick up: 3:30pm - 5:30pm

*Please list any adults other than yourself who are authorized to pick up your child.*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## **CAMP LOCATION:**

3088 Smith Springs Road, Antioch TN 37013

## **PAYMENT INFORMATION**

A non-refundable deposit of \$50 per session is required with this form. Cancellation for a session must be made at least two weeks before a session begins. All cancellations must be made in writing directly communicated to the Camp Coordinator / Director

## **FORM OF PAYMENT**

- Deposit Check Enclosed - payable to Easterseals Tennessee  
 Pay by Debit/Credit Card – payable online  
 TBI     ARC     Katie Beckett Program     TNCARE  
 Other: \_\_\_\_\_

## **SCHOLARSHIPS**

Need based financial aid is available February 1st on a first come first served basis. To apply, download a form from our website or call the camp office at 615-444-0597

## **ALL CAMP BALANCES ARE DUE 30 DAYS PRIOR TO SESSION START**

**Mail Form and Payment To:**

**Easterseals Tennessee Camp**

**960 Maddox Simpson Pkwy**

**Lebanon, TN 37090**

**P 615-444-0597 ext. 420**

**F 615-444-1251**

## DAY CAMP

Please select sessions desired

**\*Maximum 6 sessions per camper\***

**\*Maximum 10 campers per session\***

**Ages Allowed :** 7 – 20

**Costs :** \$475 per week; \$200 for a 1:1 Counselor

Does your camper need a 1:1 Counselor?  Yes  No

- Session 1      May 27 - June 1
- Session 2      June 2 – June 8
- Session 3      June 9 – June 15
- Session 4      June 16 – June 22
- Session 5      June 23 – June 29

Session 6 NO CAMP      June 30 – July 6

- Session 7      July 7 – July 13
- Session 8      July 14 – July 20
- Session 9      July 21 – July 27
- Session 10      July 28 – August 3

☺ Easterseals staff attends a mandatory week-long training prior to camp. Many staff members are college age counselors who are recreation therapy majors, special education majors, grew up with a sibling with a disability, or work in the school systems.

☺ Camp Coordinator / Director will reach out to the family and discuss necessary needs.

☺ Low staff to camper ratio of 1:3.

☺ Limited 1:1 spots are available each session.

☺ RN on site 24 hours a day.

☺ The dining lodge can accommodate most special diets. Lunch and a snack are provided for day campers.

☺ Inclusive camping. Campers ages 7-20 are in groups with their school-aged peers.

## Easter Seals Tennessee Mission

*The mission of Easterseals Tennessee is to make profound positive differences in the lives of people with disabilities as they learn, work, and play in their communities.*

**\*\* PLEASE NOTE THAT EASTERSEALS WILL NOT BE HOSTING OVERNIGHT CAMPS FOR CHILDREN DURING THE SUMMER OF 2024 \*\***

**CAMPER NAME:** \_\_\_\_\_

# 2024 EASTERSEALS TENNESSEE CAMP - HEALTH INFORMATION FORM

Nature of Disability please indicate (x) all that apply:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Attention Deficit Disorder/ADHD   | <input type="checkbox"/> Autism           | <input type="checkbox"/> Behavior Disorder                      | <input type="checkbox"/> Bleeding/Clotting Disorder |
| <input type="checkbox"/> Cerebral Palsy   | <input type="checkbox"/> Cystic Fibrosis   | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Developmental Disorder                 | <input type="checkbox"/> Down Syndrome              |
| <input type="checkbox"/> Epilepsy/Seizure Disorder  | <input type="checkbox"/> Fragile X   | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Heart, Circulatory, Respiratory Defect | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Learning Disability  | <input type="checkbox"/> Speech Language/Voice Dysfunction   | <input type="checkbox"/> TBI              | <input type="checkbox"/> Social/Psychological                   |   |
| <input type="checkbox"/> Intellectual Disability  | <input type="checkbox"/> Spinal Cord Injury  |   | <input type="checkbox"/> Visual Impairment                      | Other _____   |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Paraplegic <input type="checkbox"/> Other |   | <input type="checkbox"/> Partial <input type="checkbox"/> Other |   |

**Custodial Parent Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Custodial Parent Contact Number:** \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Policy Holder Number: \_\_\_\_\_

Health Insurance Group/Policy Number: \_\_\_\_\_ Health Insurance Company Phone: \_\_\_\_\_

## HEALTH HISTORY

Date of the Last Health Exam: \_\_\_\_\_ Are all required school immunizations up to date?  No  Yes Date of last tetanus booster (month/yr): \_\_\_\_\_

(In the "Date" space, please provide the date of last occurrence when answering yes to each health event)

- |                            |   |                   |   |                  |   |
|----------------------------|---|-------------------|---|------------------|---|
| Asthma or Inhaler          | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Behavior Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Chicken Pox      | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Bleeding/Clotting Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | ADD/ADHD          | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Homesickness     | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Poison Ivy Allergy         | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Seizures          | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Speech Problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Insect Sting Allergy       | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Bedwetting        | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Hearing Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Ear Infections    | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Fears/Phobias     | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Vision Problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Headaches         | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Sleepwalking      | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Epilepsy         | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Sore Throats      | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Head Lice         | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Other _____      | Date _____  |

Please list any Drug Allergies: \_\_\_\_\_

Please list any Environmental Allergies: \_\_\_\_\_

Please select the following over the counter medications, supplied by YMCA Camp Widjiwagan and Easterseals Tennessee, that are acceptable to administer to your child.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <b>Diphenhydramine (Antihistamine, itching, allergic reaction)</b>          | <input type="checkbox"/> <b>Tinactin (antifungal)</b>                            | <input type="checkbox"/> <b>Ibuprofen (swelling, pain relief, fever)</b>                         |
| <input type="checkbox"/> <b>Robitussin or Robitussin DM (cough)</b>                                  | <input type="checkbox"/> <b>Glucose tablets or gel/icing (hypoglycemia)</b>      | <input type="checkbox"/> <b>Acetaminophen (pain relief, fever)</b>                               |
| <input type="checkbox"/> <b>Epsom Salt (infection soak)</b>  | <input type="checkbox"/> <b>Calamine Lotion (poison ivy)</b>                     | <input type="checkbox"/> <b>Antibiotic ointment (scrapes, lacerations, wounds)</b>               |
| <input type="checkbox"/> <b>Imodium/Loperamide (diarrhea)</b>  | <input type="checkbox"/> <b>Menthol (topical pain relief)</b>                    | <input type="checkbox"/> <b>Gold Bond/Bourdreaux Butt Paste/zinc oxide (chafing)</b>             |
| <input type="checkbox"/> <b>Clotrimazole (antifungal)</b>  | <input type="checkbox"/> <b>Benzocaine/Lidocaine (topical pain relief)</b>       | <input type="checkbox"/> <b>Tums, Maalox (stomach ache)</b>                                      |
| <input type="checkbox"/> <b>Hydrocortisone (topical) 0.5% or 1% (dermatitis, rashes, poison ivy)</b> | <input type="checkbox"/> <b>Gatorade, Pedialyte (diarrhea, nausea, vomiting)</b> | <input type="checkbox"/> <b>'Swimmers Ear' drying drops or equivalent (acute otitis externa)</b> |
| <input type="checkbox"/> <b>Pseudoephedrine (nasal congestion)</b>                                   | <input type="checkbox"/> <b>Betadine Solution (scrapes, lacerations, wounds)</b> | <input type="checkbox"/> <b>Allergy Eye drops (itchy eyes due to allergies)</b>                  |
| <input type="checkbox"/> <b>Cough drops (cough)</b>  | <input type="checkbox"/> <b>Miralax or generic (constipation)</b>                | <input type="checkbox"/> <b>Redness Eye drops (irritated eyes: red, itching, burning)</b>        |
|  |  | <input type="checkbox"/> <b>Topical burn cream/gel or Aloe (burns)</b>                           |

please list any additional medications you DO or DO NOT want administered to your child. Please write N/A if nothing needs to be noted

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Is there anything that camp needs to know when giving any of the approved OTC meds to your child?

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Will your child require any special treatments while at camp?  No  Yes If yes, please explain:

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Description of any other current health conditions requiring medication, treatment, or special restrictions or considerations while at camp:

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Description of any camp activities from which the camper should be exempted for health reasons:

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Do you need a nurse to contact you about your camper prior to their arrival? YES NO

Parent/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

# 2024 ALLERGY & DIETARY RESTRICTION FORM

Camper Name : \_\_\_\_\_

Vegan

- Plant foods and products only

Vegetarian

- No red meat
- No chicken
- No eggs
- No pork
- No fish
- No dairy products at all

**Please select all the following that apply to your camper:**

Food Allergies

- Peanuts – or anything nut related
  - Fish / Shellfish
  - Eggs
  - Milk
  - Anything diary
  - Soy
  - Nut oils
  - Sugar
  - Mushrooms
  - Gluten / Wheat
  - Chocolate or desserts
  - Processed foods
  - Sulfite
  - Lupins
  - Mustard or Ketchup or Mayonnaise
- Other \_\_\_\_\_

**Please provide *additional allergy / dietary information or instructions* about your camper:**

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***For questions / concerns about the food served at camp, please contact:***

Easterseals	YMCA – Camp Widjiwagan
Jared Houtman Recreation Camp Coordinator	Front Office at YMCA
<b>P :</b> (615) 444 – 0597 ext 420	<b>P :</b> (615) 360-2267
<b>C :</b> (615) 318 – 9479	contact:
<b>E :</b> jhoutman@eastersealstn.com	<a href="http://www.campwidji.org/contact-us">www.campwidji.org/contact-us</a>

CAMPER NAME \_\_\_\_\_

## 2024 EASTERSEALS TENNESSEE CAMP WAIVER

### HEALTH EXAM

I certify that the information provided is correct and complete so far as I (the undersigned) know, that the camp activities offered at the YMCA Camp Widjiwagan and Easterseals Tennessee Camp may at times require the participants to exert themselves, and the person herein described as the camper has permission to engage in all prescribed camp activities, on or off YMCA Camp Widjiwagan premises, except as noted on this health form. I understand that it is the responsibility of the parent/guardian to inform YMCA Camp Widjiwagan and Easterseals Tennessee of any changes or additions to this form on the day the child arrives at camp. I also certify that the above-named camper has received a health exam from licensed medical personnel within the past 12 months of the time the camper will be at YMCA Camp Widjiwagan and Easterseals Tennessee Camp. I have listed any physical condition requiring restrictions on participation in the camp program and a description of such restrictions. I have also listed any current or ongoing treatments or medications.

### PERMISSION TO TREAT

I give permission to YMCA Camp Widjiwagan and Easterseals Tennessee Camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment which may include without limitation the administration of over-the-counter medications. Additionally, I hereby authorize YMCA Camp Widjiwagan and Easterseals Tennessee Camp to secure any necessary medical treatment on behalf of Camper, including the administration of anesthesia and surgery, as such may be determined necessary. I acknowledge and agree that such medical treatment shall be solely at my expense and I agree to reimburse YMCA Camp Widjiwagan or Easterseals Tennessee Camp for any expenses which it may incur on account of Camper's medical treatment by non-YMCA Camp Widjiwagan and Non- Easterseals Tennessee Camp medical providers.

### PARENT NOTIFICATION

Parents/guardian will be promptly notified upon YMCA Camp Widjiwagan and Easterseals Tennessee Camp learning of an accident/injury/illness of their child for unresolved fever above 100.5 degrees for 4 hours, unresolved vomiting x2 episodes and/or longer than 2 hours, unresolved diarrhea x3 episodes and/or longer than 4 hours, health clinic stay longer than 12 hours, overnight health clinic stay, transfer to see physician and/or to a local health care facility for emergent treatment for physical and/or psychological care, and any condition deemed necessary by the camp nurse and/or summer camp director. Parents/guardians hereby waive any and all claims to or regarding notification, or failure to notify, for minor issues that do not meet or rise to the level of those described above.

### PERMISSION TO APPLY BUG REPELLENT AND SUNSCREEN

I give permission to YMCA Camp Widjiwagan staff and Easterseals Tennessee Camp staff to apply bug repellent and sunscreen to my child if they need assistance in doing so (If your camper has allergies to certain ingredients in either one of the above please send sunscreen and, or bug repellent that they may use while at Camp. Please mark with campers first and last name)

### PARTICIPATION WAIVER

I approve this application and certify the Camper is capable of such an experience. I agree to have the balance of the camp fees paid before the beginning of the session(s) reserved. Camp fees are non refundable without a doctor's authorized medical reason. I understand that no refunds are given if a child leaves early because of home sickness or for disruptive behavior, as determined by the Easterseals Camp Director. I understand that the deposit is not refundable under any circumstances. I grant permission for the applicant to participate in all planned camp activities, including out of camp trips by bus or van, hiking, rock climbing, horseback riding, or swimming. The YMCA and Easterseals Tennessee Camp are not responsible for lost, stolen or damaged personal items. I agree to waive any claims against the YMCA and Easterseals Tennessee and its members, staff and volunteers for injuries or damages that my result from the conduct of third parties other than the YMCA Camp Widjiwagan , Easterseals Tennessee and its members, staff, and volunteers, but including participants in YMCA or Easterseals Tennessee Camp programs. All waivers and agreements provided herein are being given as additional consideration for Camper's attendance at, and participation in the activities of, YMCA Camp Widjiwagan and Easterseals Tennessee Camp.

### PUBLICITY WAIVER

I give permission to YMCA Camp Widjiwagan and Easter Seals Tennessee Camp to take photographs and/or audio/video recordings of my child and to use them for educational, professional, and publicity purposes for YMCA Camp Widjiwagan, YMCA of Middle TN, Easterseals Tennessee Camp and its Community Partners.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CAMPER NAME:** \_\_\_\_\_ **2024 EASTERSEALS TENNESSEE CAMP - CAMPER'S CARE INFORMATION**

**Mobility** Walks Uses walker Uses wheelchair, can propel/drive self Yes No

**Transfers** No assists needed Needs assistance (explain): \_\_\_\_\_

**Assistive Devices** None AFO's Glasses Hearing aid Helmet Other: \_\_\_\_\_

**Communication** No serious difficulties expressing thoughts or want Has difficulties (explain): \_\_\_\_\_

Uses sign language Uses a communication device (what kind): \_\_\_\_\_

**Eating** No assistance needed Needs assistance (explain): \_\_\_\_\_

**Diet** Normal Blended/Pureed Diabetic Dairy Other (explain): \_\_\_\_\_

Special - please attach a list of special diet so we can determine if we can meet your need

**Bowel Control:** No assistance needed Incontinent Needs assistance/schedule: \_\_\_\_\_

**Aids used:** None Catheter Disposable undergarments Other: \_\_\_\_\_

**Dressing:** No assistance needed Assistance needed (describe): \_\_\_\_\_

**Washing/Showering (If Applicable)** No assistance needed Some assistance needed (describe) \_\_\_\_\_

Total assistance needed (describe): \_\_\_\_\_

**Sleeping (If Applicable)** Not Applicable Typical sleeping habits Has trouble going to sleep Has nightmares Sleep walks

Special bedtime routines: \_\_\_\_\_

Usual bedtime: \_\_\_\_\_ Usual wake up time: \_\_\_\_\_

Individuals 16 or older may sleep on the upper bunk with parent or guardian's permission. To give your camper permission to use the upper bunk, please initial here: \_\_\_\_\_

### Camper's Social Background

School \_\_\_\_\_ Grade level \_\_\_\_\_ Can the camper read? Yes No Can the camper write?  Yes  No

Does the camper have any special behaviors? Yes No

If yes, please describe \_\_\_\_\_

When do these behaviors occur? \_\_\_\_\_

Describe effective methods to control difficult behaviors: \_\_\_\_\_

Please list any fears the camper may have: \_\_\_\_\_

Please list any activities the camper dislikes: \_\_\_\_\_

What hobbies or activities does the camper enjoy at home or school? \_\_\_\_\_

Please add any information you feel would be helpful in providing the best experience for the camper while at camp: \_\_\_\_\_