A Residential Care Agency

"Committed to changing the world... one life at a time."

Sonshine Cove
Camper Information Sheet

PLEASE CIRCLE CAMP PERIOD DESIRED:

- September 21-23, 2018
- October 19-21 ,2018
- November 16-18, 2018
- December 14-16, 2018
- January 18-20, 2019
- February 15-17, 2019
- March 11-15, 2019(March Break)
- April 12-14, 2019
- May 17-19, 2019
- June 14-16, 2019

NAME OF CAMPER_____
DATE OF BIRTH_____
Male/Female_____
ADDRESS_____
TELEPHONE_____
EMAIL ADDRESS_____

Parent 1 / Primary Contact:	Name	Cell or Home phone	Email
Parent 2 / Secondary Contact	Name	Cell or Home phone	Email

LEGAL GUARDIAN_____
OHIP #_____

ONLY IF APPLICABLE TO YOUR CAMPER
SONSHINE WORKER_____
REFERRING AGENCY AND/OR SOCIAL WORKER_____
(i.e. C.A.S., Service Coordination)

Please check all that apply:

_ Developmental disability **_Seizure disorder**
_Cerebral Palsy **_Autism Spectrum Disorder**
_Diabetes **_Hearing impairment**
_Down syndrome **_Heart conditions**
_ Spina Bifida **_Visual impairment**
_Pervasive Developmental Disorder _ODD _ADD/ADHD
_Asthma or respiratory concerns **_Tourette's syndrome**
_Communication Disorder **_Other**

Medical Information:

Does your camper use any of the following? Please check all that apply

o Wheelchair	o Jogger	o Earplugs	o Hearing aids	o Adapted floatation device
o Shunt	o Terra Track	o Catheter	o Inhaler	o Glasses/contacts
o Tubes (in ears)	o G-tube	o Epi-pen	o Orthotics	o Helmet for daily use

If your camper uses a wheelchair, are there any concerns you feel we should be aware of, such as recent operations, illness, skin rashes, etc?_____
_____
_____
_____

If your camper requires supportive lifting, please provide their weight: _____ lbs.

Does your child wear ear plugs for water activities? o No o Right ear o Left ear o Both

Please describe any pertinent medical information or present treatments you feel we should be aware of (recent medical procedures, illnesses, rashes, etc.)_____
_____
_____

Transportation:

Can your camper sit independently? o Yes o No

Does your camper require assistance or restraints (belt, harness, adapted seat) o Yes o No

If YES, please explain
Does your camper take Para-Transpo transportation o Yes o No

<u>Communication:</u> How does your camper communicate?

Please select all that apply
o Functional speech o Gestures o Leading/pointing o Sign language
o PIC-SYM o Picture Exchange Program (PECS) o Isolated sounds
o Picture/photo book
o Other

<u>Is your camper capable of:</u>

Responding appropriately to supervision o Yes o No
Being responsible for their own belongings o Yes o No
Working with a group of peers o Yes o No
Communicating in sentences o Yes o No
Communicating with gestures or sounds o Yes o No
Carrying out tasks when shown how o Yes o No
Eating socially in a group o Yes o No
Following simple instructions o Yes o No

Does this camper require any specialized equipment i.e. Hoyer Lift, commode, roll-in shower etc.
_____
_____
_____

Allergies: _____

Does your child experience any difficulty in social settings? o Yes o No
When does it occur and how do you recommend we respond?_____
_____
_____
_____
_____

Please list potential problems for your child at camp (i.e. wandering, water, fears, etc.) and how do you recommend we respond?
_____
_____
_____
_____
_____
_____

Does your camper experience behavioural/social difficulties (i.e. physical aggression, tantrums, running off)? o Yes o No
When does it occur and how do you recommend we respond?_____
_____
_____
_____
_____
_____

Does your camper have issues around bedtime routines and/or sleeping through the night or sleep walking/wandering?_____
_____
_____

What, if anything triggers these behaviours?_____
_____
_____
_____
_____

Favourite Activities **Least Favourite Activities**

_____

_____

_____

Please list any activities your child cannot participate in due to medical reasons:_____

_____

_____

Camper Self-Care Abilities:

Task	Independent	Needs some help	Dependent on Staff
Dressing/Undressing			
Washing Hands			
Sitting			
Walking upstairs or Hills			
Swimming			
Toileting			
Menstral Hygiene			

Please List all Medications, including dosage and frequency:(Please enclose all medication bottles with original prescription labels in a sealed baggie with the camper's name and medication sign off sheets (if available)

Medication Dosage Administration time Reason for taking

Medication	Dosage	Administration	Time	Reason for Taking

Is your camper toilet trained? o Yes oNo
Does your camper wear diapers or other personal care items o Yes o No
Describe the support your child needs in toileting/changing_____
_____

Describe the guidance/assistance your child needs at meal times:_____
_____
_____

Please list any special dietary needs, restrictions or food allergies_____
_____
_____

Additional Supportive Information;
What level of support does your camper receive at school or day program?_____
_____

Please include any information, which would be helpful to the camp staff in insuring a positive camp experience for your camper.

_____
_____
_____
_____
_____
_____

I have reviewed this form and completed it to the best of my knowledge and beliefs.

Parent/Guardian Print Name Signature Date Completed