Youth Outdoor Expedition Application

Access Services is committed to providing an excellent overnight camping experience for every camper. Please fill out this application thoroughly; honest and accurate information enables us to provide optimal, personalized care. Please print or write clearly. Questions? Call 215-421-8527 or email JGentile@accessservices.org. Thank you.

CAMPER:

First Name ____ MI ____ Last Name ____

Street ____ Phone ____

City ____ State ____ Zip ____

School ____

SS# ____ Age ____ Date of Birth ____

PARENT/LEGAL GUARDIAN:

First Name ____ MI ____ Last Name ____

Street ____ Home Phone ____

City ____ State ____ Zip ____ Cell Phone ____

EMERGENCY CONTACTS:

First Name ____ MI ____ Last Name ____ Relationship ____

Street ____ Home Phone ____

City ____ State ____ Zip ____ Cell Phone ____

First Name ____ MI ____ Last Name ____ Relationship ____

Street ____ Home Phone ____

City ____ State ____ Zip ____ Cell Phone ____

MEDICAL INSURANCE:

Company ____ Policy Holder ____

Policy Number ____ Primary Care Physician ____

Street ____ Phone ____

City ____ State ____ Zip ____ County ____

CAMPER PHYSICAL DESCRIPTION:

Height Weight

Eye Color Hair Color Race

Medical Conditions/diagnosis

Allergies (reaction and response required)

Dietary Restrictions:

Physical Restrictions:

Other information that would be pertinent for us to know:

Medication Name Reason for Medication:

Dosage Directions

Medication Name Reason for Medication

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Medication Name Reason for Medication

Dosage Directions

Application: can be sent as soon as possible. The completed application form will hold the camper's space for the camp. Please send completed copy of the application to the address below.

Health Forms: A current physical (within two years) is due 10 days before the camper is scheduled to come to camp. NO EXCEPTIONS. Please have the physical signed by the child's physician.

Transportation: Campers using Access Services, Inc. transportation please use the designated schedule for pick up sites. Campers who are using transportation are responsible to get to the pick-up site and to get home from the drop off site. Please communicate with the camp director in the event of an emergency.

Personal Items: Please review the list of items that each camper is expected to bring. Personal items must be limited to those that are necessary; items such as electronics should be left at home. Inappropriate items will be confiscated and returned to campers at drop-off. Access Services is not responsible for lost or stolen items. Please have personal items clearly labeled.

Please scan this document to JGentile@accessservices.org or fax to 215-540-2165 or mail it to the address below:

Access Services
Attn: Julie Gentile
500 Office Center Drive, Suite 100
Fort Washington, PA 19034

Camper Interview Form

Does the child/teen have a diagnosis? If yes, what is it?

What services/supports are in place now? (mental health, specialized school placement, etc.)

What is the focus of those services (treatment goals)?

How does this child/teen relate to their peers? Do they have friends?

How does this child/teen handle conflict?

How much help does this child/teen need in order to follow instructions and complete tasks?

Are there any triggers or situations that this child/teen is likely to have difficulty with?

What has worked in the past to redirect and/or effectively manage behavioral situations?

Has this child/teen been away from home overnight before?

Are there any other special instructions or information that we should know when supporting this child/teen?

Camper Questionnaire

What is your preferred Name (Nickname)?

What is your favorite idol or hero?

What is your biggest fear?

What makes you really angry?

What is your favorite sport to watch_________________To play__________________?
Can you swim ❒ No ❒ Yes Have you ever camped before ❒ No ❒ Yes

What do you like to do for fun?

What is your favorite TV show/video game?

What is your favorite type of music?

What is your favorite food?

What do you feel you do really well?

What is your greatest accomplishment?

What do you want to be when you grow up?

What is your most prized possession?

Who is your favorite person outside your family?

What are you most looking forward to doing at camp?

What are you least looking forward to at camp?

EMERGENCY HOSPITAL TREATMENT FORM:

I/we the parent(s)/legal guardian of____give my/our permission for emergency medical/dental treatment to be given if necessary.

I/we understand that I/we will be notified of any emergency by the Camp Coordinator as soon as possible.

____

Signature Relationship to Individual Date

____

Witness Relationship to Resident Date

RELEASE OF INFORMATION:

I,_________________________________, hereby authorize the Camp Department at Access Services, Inc. to obtain and/or release the following documents or information to providers in order to coordinate and facilitate services for____________________________________.

- ❒ Psychological Evaluation
- ❒ Physical examination
- ❒ Psychiatric Evaluation
- ❒ Neurological Exam
- ❒ Educational Assessment
- ❒ Initial Assessments
- ❒ Medical Evaluation/Information
- ❒ Intake Documents/Application
- ❒ Other _________________________________

____

Parent/Guardian/Client Date

This form expires one year from the signed date.

Our Privacy Policy – This briefly summarizes how your personal health information is protected and how it is used. The full description of how we use and protect your health information is contained in our Notice of Privacy Practices. The notice explains your rights to inspect, copy, and amend your medical information. It also outlines your rights to restrict or limit how we use and share your health information. We strongly encourage you to read our Notice of Privacy Practices and ask questions if you don't understand. It is important for you to understand how your health information may be used and what your rights are regarding your health information. You will be asked to acknowledge that you have received our Notice of Privacy Practices. For more information, please contact our Privacy Officer at 215-540-2150.

Please sign below to acknowledge receipt of our Notice of Privacy Practices

____

Individual or Personal Representative's Signature Printed Name Date

If signed by a personal representative, please indicate name of person for whom it is signed: _________________________________

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Fort Washington, PA 19034

Other Releases

TRAVEL PERMISSION:

To be transported by Access Services Staff and volunteers. Transportation will be for emergency, activity and camp related circumstances.

Parent/Guardian Signature Date

RELEASE FOR RECREATIONAL ACTIVITIY:

To participate in recreational/sporting activities while in camp with Access Services. Recreational activities may include but are not limited to; canoeing, hiking, fishing, low ropes course, high ropes course, swimming, and organized sports. I release and hold harmless Access Services and the host family provider from any liability for injuries that may result during the course of any recreational activity.

Parent/Guardian Signature Date

PHOTO/VIDEO/STORY RELEASE:

I, the undersigned self, parent, or legal guardian, intending to be legally bound by this release, authorize Access Services to use photographs or video of and/or stories about the individual, myself or my child for Access Services promotional materials. Materials are described as including but not limited to newsletters, display boards, financial appeals, video and other marketing presentations. I understand that if a story is used the actual name will be used unless I specifically request in writing the use of a fictitious name to protect identity. I realize this authorization is for the express purpose of furthering the work of Access Services. I understand that I am not entitled to any remuneration for my photo or story and I waive any rights to payments or royalties. I specifically release Access Services from any claims and any liability arising in any way whatsoever from the making, distribution or use of this promotional material. I understand that I can rescind this authorization at any time by written request and that such rescission will be applicable to all publication and use after the date of receipt, but that materials distributed prior to the rescission will not be withdrawn.

Type/Description of Publicity

Printed Name of individual featured Signature of self

Signature of legal guardian or parent Date

Witness Date

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Fort Washington, PA 19034

Physical Form

GENERAL INFORMATION:

First Name | MI | Last Name

Address | Phone

City | State | Zip

Date of Birth | Sex | Height | Weight

In Emergency Notify – Name | Phone

Personal Physician – Name | Phone

Address

HEALTH HISTORY:

Allergies (reaction and response required) /Contraindicated Medications

Current Medications

IMMUNIZATIONS:

Type	Yes	No	Type	Yes	No	Type	Yes	No
Flu			Measles/Mumps/Rubella			Polio		
Tetanus			Hib/Meningitis			Hepatitis		
Diphtheria			Pneumococcal/Pneumonia			Other		

Health over the last year

Chronic Conditions/Present Illnesses

Please check any symptoms or conditions that you have experienced:

- ❒ Seizures
- ❒ Rheumatic Fever
- ❒ Hepatitis
- ❒ Diphtheria
- ❒ Chorea
- ❒ Cancer
- ❒ Mumps
- ❒ TB
- ❒ Hypertension
- ❒ Meningitis
- ❒ Tonsillitis
- ❒ Measles
- ❒ Diabetes
- ❒ Asthma
- ❒ Typhoid
- ❒ Pneumonia
- ❒ Stroke
- ❒ Back Injury
- ❒ Endocrine & Metabolic Disorders
- ❒ Other

Please describe any checked items:

Previous surgery or hospitalizations/other conditions?

____

____

CLINICAL EVALUATION:

Type	Normal	Abnormal	Describe Abnormal Findings
Head/Neck			
Eyes			
Ears			
Nose			
Mouth			
Throat			
Teeth			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Hernia			
Arms			
Hands			
Legs			
Feet			
Spine			
Skin			
Lymph Nodes			
Neurological			

LABORATORY WORK ORDERED:

Mantoux Test Location

Mantoux Results Date Read

CLINICAL IMPRESSIONS/WORK RESTRICTIONS:

As far as can be determined from this examination, is the patient able to participate in camp activities as described? ❒ Yes ❒ No

As far as can be determined from this examination, is the patient free and clear of all communicable diseases and/or medical problems which might interfere with the health, safety, or well-being of other individuals? ❒ Yes ❒ No

If no, what precautions need to be taken or what other information is necessary to insure the health/safety of other individuals?

Signature of Physician, Certified Nurse Practitioner, or Registered Assistant Date

Print or Stamp Name Phone

Address

City State Zip

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