



# Camp Freedom July 5 – 8, 2012

Spina Bifida & Hydrocephalus Association of Northern Alberta  
P.O. Box 35025 – 10818 Jasper Ave  
Edmonton, Alberta, T5J 0B7

**Please mail this completed form, with your full payment and current membership, to the SBHANA office before May 31<sup>st</sup>. Late registrations will not be accepted.**

### Camper Application

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Adult t-shirt size: S M L XL

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Date of birth(M/D/Y): \_\_\_\_\_

**Emergency Information** – It is important that we be able to reach at least one of the emergency contacts on a 24-hour basis for the duration of the camp

### **Parent(s)/Guardian**

Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell) \_\_\_\_\_ (other) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

### **Alternate Contact**

Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell) \_\_\_\_\_ (other) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

### Medical Information & Level of Care

Does the camper use: Electric Wheelchair  Manual Wheelchair

Braces  Crutches

Walker

Medical Conditions (e.g. seizures, high blood pressure, asthma) \_\_\_\_\_

Food Allergy:  Yes  No Description: \_\_\_\_\_

Latex Allergy:  Yes  No Reaction: \_\_\_\_\_

Does camper carry an Epi-pen:  Yes  No

Shunt:  Yes  No Frequent Headaches:  Yes  No

Intermittent Catheterization:  Yes  No How often: \_\_\_\_\_

Completely Independent:  Yes  No Mitrofanoff:  Yes  No

Does the camper require assistance for catheterizing with any of the following:

With Clothing:  Yes  No Reminders to cath:  Yes  No

For Transfers:  Yes  No Requires a nurse to cath:  Yes  No

Does Camper use an anal plug for swimming  Yes  No

If yes, do they require assistance  Yes  No

Please describe the assistance or support required by the camper in each of the following activities. If the camper is independent, please indicate.

Eating/Drinking: \_\_\_\_\_

Showering: \_\_\_\_\_

Dressing: \_\_\_\_\_

Transfers in/out of wheelchair: \_\_\_\_\_

Does the camper have a Mace or Cecostomy tube or any other bowel routine. Give details on which day and time routine done / assistance required / length of time to complete: \_\_\_\_\_

Please describe any other pertinent information the camp counsellors should know: \_\_\_\_\_

## Transportation

A camp bus will be available to transport campers to and from Camp Freedom at no charge. The drop-off/pick-up spot is from the west-end of Edmonton. Further information, along with a list of things needed at camp, will follow in an acceptance package.

Do you require bus transportation:

**To camp**             Yes    No

**From camp**         Yes    No

Will you be bringing a wheelchair to camp?         Yes    No

If Yes, Are you able to walk onto the bus?         Yes    No

Do you require a wheelchair lift?                     Yes    No

Can you transfer to a seat independently?         Yes    No

Do you require wheelchair tie downs?             Yes    No

## Fees

Early registration camp fees are \$175 for applications received before May 1st.

After May 1st, the regular fees are \$300.

**No registrations will be accepted after May 31<sup>st</sup>.**

Camp Freedom includes bus transportation to/from camp, 3 nights dormitory style accommodation, 3 hot meals per day, snacks, continuous beverages, and all recreational activities for the duration of the camp.

Cheques are payable to the SBHANA, and must be submitted with your application to guarantee your attendance. Sorry, but no spots will be held without payment.

- No camper will be denied attendance due to financial constraints. Please call our office if you wish to apply for funding assistance through the SBHANA

## Camp Freedom Participation Agreement

This form is to be completed by a parent or legal guardian.

Name of camper: \_\_\_\_\_

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

Date of birth (M/D/Y): \_\_\_\_\_

This camper wishes to participate in the activities at Camp Freedom and as a condition of participation, the camper's parent or legal guardian agrees to the following:

1. I am aware that Camp Freedom provides activities such as water sports, ropes course and other physically active games that could result in stress or injury. I waive any action or claim against Camp Freedom, the SBHANA and Camp HeHoHa for any accident or injury except to the extent that such accident or injury is due to the negligence of Camp Freedom, its employees or agents.
2. I agree to pay any costs incurred by Camp Freedom in the proper care of the Camper over and above the camper fees. (Transportation in the event of an early return, medication, ambulance services, damage to property.)
3. I consent and authorize such medical and or hospital care as deemed necessary by the medical authority of Camp Freedom.
4. I give permission to Camp Freedom and the SBHANA to use my child's photograph and/or video recording for future publications of promotional material and newsletters without monetary compensation.

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

Relationship to camper: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Date (M/D/Y): \_\_\_\_\_

**Medical Form**

This form must be completed by the Camper's Physician and returned to the SBHANA office with your application form.

Name of patient: \_\_\_\_\_

Date of birth (M/D/Y): \_\_\_\_\_

Disability: \_\_\_\_\_

**Camp Freedom** is a camp for teens with Spina Bifida. Counsellors and nurses will be on hand to assist with personal care and recreational activities as needed

1. Is this patient subject to seizures?  Yes  No

Frequency of seizures: \_\_\_\_\_

Duration: \_\_\_\_\_

Description of seizures: \_\_\_\_\_

Behaviour after seizure: \_\_\_\_\_

Recommended treatment: \_\_\_\_\_

2. Is this patient subject to allergies? (Include drugs, latex, insects, food)

Allergies: \_\_\_\_\_

Reaction: \_\_\_\_\_

Recommended treatment: \_\_\_\_\_

3. Is this patient on a special diet?  Yes  No

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

4. Is this patient on medication?  Yes  No

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time(s) Given: \_\_\_\_\_ Oral or other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. **Provincial Health Care Number:** \_\_\_\_\_

Does the camper have additional Medical Coverage if residing out of Alberta? \_\_\_\_

If so, please give Insurance information: \_\_\_\_\_

6. What is the patient's normal blood pressure and pulse? \_\_\_\_\_

7. Is this patient prone to any of the following conditions?:

Asthma or respiratory problems  High blood pressure

Bladder infections  Anxiety attacks

Headaches  Skin breakdown

Diarrhea  Constipation

Upset Stomach

Other \_\_\_\_\_

What should be done if these problems occur at camp? \_\_\_\_\_

\_\_\_\_\_

8. Can this patient have Tylenol 500mg as needed for a headache?  Yes  No

9. Is this patient able to participate in the following activities?

(All activities are adapted to the abilities of the individual.)

Swimming  Yes  No

Canoeing  Yes  No

Climbing wall  Yes  No

Wheelchair accessible low ropes course  Yes  No

What precautions would you recommend? \_\_\_\_\_

\_\_\_\_\_

10. Do you have any other recommendations for this patient? \_\_\_\_\_

\_\_\_\_\_

Name of Physician: \_\_\_\_\_

Date: (M/D/Y) \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

**Signature of attending physician:** \_\_\_\_\_