Dear Camper/Caregiver/Family:

Welcome to the Colorado Lions Camp! Thank you for your interest in attending our Weekend Respite Camps. We have many fun & exciting activities planned, and look forward to seeing you there. Please note, we will have a total of **10** spots open for each scheduled weekend. Openings will be filled on a first come, first serve basis, so please make sure to complete your application quickly. Get ready for an awesome time!

Respite Camp Dates

#1 October 14-16, 2022(Friday-Sunday) Respite Cost 250.00/300.00 for Special Diets
#2 November 11-13, 2022 (Friday-Sunday) Respite Cost 250.00/300.00 for Special Diets
#3 December 8-11, 2022 (Thursday-Sunday) Respite Cost 350.00/400.00 for Special Diets
#4 March 3-5, 2023 (Friday-Sunday) Respite Cost 250.00/300.00 for Special Diets
#5 April 14-16, 2023 (Friday-Sunday)Respite Cost 250.00/300.00 Special Diets

Required Materials:

- Completed 2022-2023 Respite Camper Application (all pages)
    - All paperwork must be filled out completely and signed.
- Camp Registration Fee - $100.00
    - Check, Money Order or Credit Card or unless billing Medicaid or agency, then no registration fee is required. Camp must receive Medicaid/agency authorization **prior** to scheduled respite date(s). Please make checks/money orders payable to: Colorado Lions Camp

Medical Forms: Physicals no later than **12 MONTHS** from your selected camp date will be accepted. All new campers are required to have a current physical on file at camp. The physical must be signed by a physician and must be on CLC's camp physical form. Physicals **MUST ARRIVE NO LATER THAN TWO WEEKS PRIOR** to the camp session you are accepted to.

Please note that acceptance guidelines, check-in & check-out procedures may change due to CDC and American Camp Association guidelines. Updates will be sent out to campers, families and agencies once guidelines have been updated and put into place.

Please email or call Colorado Lions Camp at clcoffice@coloradolionscamp.org or (719) 687-2087 for any additional information.

Yours in Camping,
Colorado Lions Camp

Colorado Lions Camp
RESPITE CAMP PROGRAM

The Colorado Lions Camp mission is to provide exceptional camping programs to individuals with varying abilities which promote independence, challenge their abilities and provide opportunity to discover his/her own potential in a safe, positive environment.

Eligibility Requirements:

1. Our program is specially designed to meet the needs of campers age 8 to senior adults, and who are: deaf or hard of hearing, blind or visually impaired, developmentally challenged, physical impairments and other mental conditions. Campers who use manual wheelchairs or walkers are able to perform the basic independent living skills and be able to use the toilet facilities without assistance. Campers must be able to maneuver up/down an incline, as the camp is built on a mountainside. If you have any questions regarding eligibility, please contact the camp at (719) 687-2087.

2. Applicants will be required to possess basic independent living skills such as, self-feeding, showering, dressing and toileting. **Applicants must be continent, have normal bowel and kidney function and control.** Applicants must display self-sufficient skills as to **NOT require one-on-one supervision** and can be managed with a 1:4 staff to camper ratio. Due to the age range of our campers, no camper will be accepted that cannot be in contact with those under 18.

Applicants that are NOT accepted:

- Incomplete applications.
- Persons that have a contagious or infectious disease.
- Persons who are incontinent and unable to take care of their personal hygiene needs.
- Persons who are medically fragile, whose needs exceed our ability to care for them adequately.
- Persons with challenges that would limit their ability to benefit from camp group activities. This includes physical, behavioral, and/or emotional issues that would require one-on-one supervision.

***During Respite Weekends, a licensed RN, LPN, MA or QMAP trained staff member will be available to administer medications. Staff members are first aid and CPR certified. All emergencies will go straight to the local hospital.**

Letter of Confirmation

If eligible, a letter of confirmation and packing list will be mailed to the applicant or parent/caregiver upon acceptance.

Cancellation Policy

All advanced fees paid will be refunded in full if notice is received in the Colorado Lions Camp office within fifteen (15) days prior to the applicants' session. If less than fifteen (15) days notice is received, all but the deposit will be refunded. If the applicant has not paid the deposit, the applicant will be billed. Promptly notify the camp in the event of a cancellation.

Colorado Lions Camp
IMPORTANT CAMP INFORMATION

1. **Check-In Time:** Registration starts at **3:30 p.m.** and will continue until **6:30 p.m**. on the **FRIDAY** of each designated respite weekend. Parents/caregivers will be required to stay through the entire check-in process. You may choose to sign an inventory waiver to expedite the check-in process, but you will still need to meet with our Camp Nurse and CLC Executive Director. **We are unable to accommodate early check-ins. Please note that check-in & check-out procedures may change due to CDC and American Camp Association guidelines. Updates will be sent out to campers, families and agencies once guidelines have been updated and put into place.**

2. **Check-Out Time: Camper check-out is no later than 11:00am on SUNDAY** morning. There will be a **$75/hour** charge for all late pickups, so please plan accordingly.

3. **Clothing List and Special Equipment:** A detailed clothing list will be provided upon notification of acceptance to the camp. Please bring warm clothing. Laundry facilities are not provided. All clothing and special equipment should be clearly marked with the camper's full name **BEFORE** check-in on Friday. **The camp is not responsible for lost, misplaced, or damaged items. Soiled clothing may be discarded and not returned.**

4. **Supervision:** Activities are well supervised and staff members are required to complete the CLC training program. Supervision is provided 24 hours a day; however, 1:1 supervision is **NOT** available. In addition, we cannot accept individuals who are not permitted to be around persons under 18 years of age.

5. **Health Care/Med Check-In Procedure:** Medical personnel are on-duty 24 hours a day for the duration of the respite weekend. The Camp Nurse is responsible for administering all medications as ordered by the physician or CLC Standing Orders. Doctors are on-call for CLC in the event they are needed. **A three-day supply of medicine must be sent with your camper for respite weekends.** All medication (pills) **MUST** be pre-poured into a med minder box by the camper's pharmacist/parent/caregiver/agency. You will need to include the original prescription bottles with one pill inside and/or bubble packs with remaining pills for verification. Any medication changes must be verified by a physician in writing or the camp's medical staff will refuse to administer it. Any medication not in the original container will not be accepted. A signed liability release statement must be signed by the person who pre-poured the medication(s) and provided to the medical staff at the time of check-in. Parents/caregivers will be contacted if medication problems arise. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**

6. **Scheduled Activities:** Arts and crafts, hobbies, nature studies, exploring, games, hiking, archery, singing, dancing, air hockey, board games, team building, and open campfire are some of the activities that may take place during the session. Persons trained in that area of interest will oversee all activities.

7. **Facilities:** Dormitories, medical exam room, two story main lodge, on 46+ acres.

8. **Insurance:** Campers are covered by the camp's accident insurance during their stay. Pre-existing conditions are covered by the individual's group medical insurance during the period they are at camp. Insurance of the family/caregiver/camper has first coverage. It is imperative that insurance and medical information be provided on the attached forms.

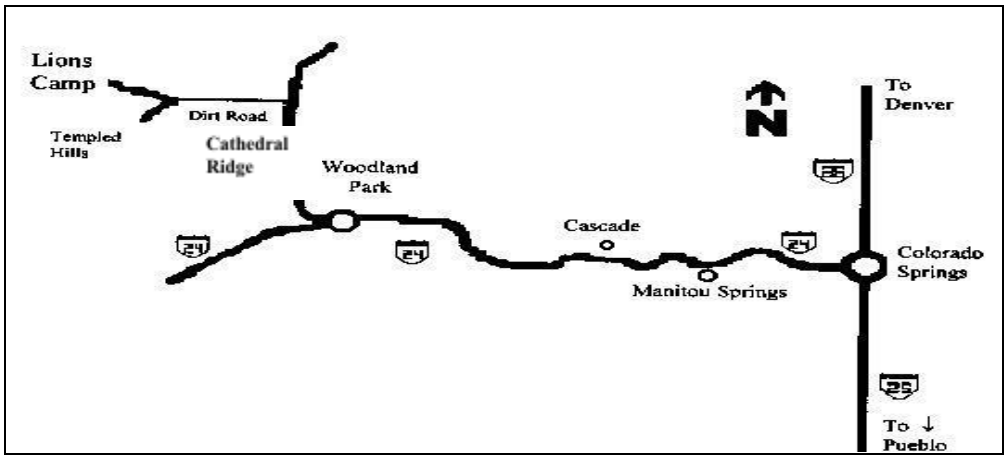
9. **Licensing:** The Colorado Lions Camp is licensed annually, according to the standards of the Colorado Department of Human Services and the Colorado Department of Health.

10. **Transportation:** Parents/Guardians/Caregivers are responsible for arranging transportation to and from camp. The camp does not provide transportation, nor cover the cost of transportation.

Where are we Located?

Camp Physical Address:

28541 Hwy 67N
Woodland Park, CO
80863



- **From I-25 in Colorado Springs take US 24 West (Exit 141) towards Pikes Peak and Manitou Springs.**
- **In Woodland Park turn North US 67 North.**
- **Proceed for four miles and you will see a large yellow sign on the left pointing towards to the camp. (On the right side you will see a sign Red Rocks Campground)**
- **Turn left at the sign onto the dirt road and keep to the right at the fork in the road. It is approximately one mile from HWY 67.**

How do I prepare my camper's medication for check-in?

All medication, vitamins and supplements must be pre-poured/prepackaged in a med minder box by a pharmacist, parent/caregiver, or agency. See pictures listed below.

	• Packaged at home in a med-minder box for each day of the week. If the camper has meds throughout the day at different times, please provide weekly boxes for breakfast, lunch, dinner or other time meds.

Please bring the pre-poured med minder box, the original prescription bottle(s) and/or bubble pack(s) showing the current prescription information, **AND** the signed liability release statement signed by the caregiver/parent/agency who poured the medication. Each bottle must contain one pill left inside the bottle for verification purposes. This includes vitamin and homeopathic supplements prescribed by a physician. You will receive additional information in your camper confirmation packet. Please ensure this process is followed to allow for the check-in process to go as smoothly as possible.

For Office Use Only:

Application Rec'd _____ Approved by_____

Deposit Rec'd _____ Week _____

Amount Due: _____

Nurse_____ Entered _____ Conf. Pkt. Sent _____

Respite Camp Application

All pages 1-10 of the application MUST be completed and returned to our office for registration.

Applications are processed on a first come, first served basis. ***DO NOT*** *wait for medical forms to be completed before sending in your application. Many of our sessions fill up quickly and you may not be placed in your first choice.*

Camper's Name_____Nickname_____

Camper's Mailing Address_____

City_____ State_____ Zip Code _____

Age_____Date of Birth_____Sex: M / F Returning camper? Yes or No T-Shirt Size:_____

Parent/Caregiver/Group Home Name and Address_____

Phone Number: Home: (___) _____ Work: (____) _____

Parent's Employer Name & Address_____

Camper lives with: ☐ Independently ☐ parents ☐ group home ☐ host home ☐ foster family

Primary Email: _____

#1 Emergency Contact Information

(Must be someone OTHER than the above listed parent/guardian)

Name_____ Relationship_____

Phone_____

#2 Medical Emergency Contact Information

(Who should be contacted if the camper needs to go to the ER, etc.?)

Name_____ Relationship_____

Phone_____

Choice of Respite Camp Session: First_____ Second_____

PAYMENT INFORMATION: (This portion must be filled out for ALL campers.)

*** Camp costs $250.00. The $100.00 registration fee is part of the total camp fee.**
*** Full payment is due by the start of the session, unless a CCB/Agency has agreed to pay the full camp fee or the camp will be billing Medicaid.**
*** CLC accepts credit card payments for full camp fees. Call the camp office for more information.**
*** No refunds will be made if the camper leaves camp because of behavior problems, illness, or other reasons by the Executive Director.**

The Camper's fee will be paid by (please fill in all that apply):

$_____Parents $_____Self $_____Medicaid* SLS or CES Waiver $_____Agency $_____CCB

***IF WE ARE TO BILL MEDICAID - WE MUST BE GIVEN A SERVICE PLAN WITH CLC INCLUDED.**

If CCB or Agency will be paying, please fill out the following information completely:

Name of Agency/CCB:_____ Contact Person:_____

Phone Number: _____

The Colorado Lions Camp is licensed through the Department of Human Services, and as the licensing agency, they require the following information. The Civil Rights Act of 1964 prohibits the discrimination based on race, color, religion, sex, nor national origin. This information will not be used to determine the eligibility of your camper.

Ethnic Heritage: (circle one) Asian Hispanic Black Native American White Other_____

Please provide the name(s) of anyone not authorized to pick up camper: _____

PARENT/CAREGIVER CHECKLIST

Camper Name_____

PLEASE READ AND INITIAL ALL THE FOLLOWING LINES AND RETURN WITH APPLICATION:

The camper application and camper questionnaire forms are **completely** filled out and signed by the legal guardian. Please note that these forms should be forwarded to the camp as soon as possible to reserve your preferred camp date. INITIAL_____

The medical form is completely filled out by authorized medical personnel only and signed by a doctor. *All campers must have a medical report on file with the camp no older than 12 months of the date of their camp session.* Medical forms must be returned **TWO WEEKS** prior to camp. **Failure to return the Medical Report may result in the camper being dropped from the session and no refund will be given.** INITIAL_____

I understand that all medications MUST be pre-poured in a med-minder box by a pharmacist, parent/caregiver, or agency. I must bring the original bottles with one pill in the original container and/or complete bubble pack with remaining pills (this includes vitamin supplements.) Any changes in how the medication is given, or in a dose that differs from those on the bottle, must be verified by a physician in writing or the our medical staff **WILL REFUSE** to administer medication. Any medication not in the the original container will not be accepted. A signed liability release statement must be signed by the person who pre-poured the medication to give to the nurse at the time of check-in. Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician. INITIAL_____

I understand that the Colorado Lions Camp does **NOT** provide **1:1 supervision** and if the camper has inappropriate behaviors or requires 1:1 attention, the camp may require me to pick up the camper before the end of the scheduled session**. No refunds will be made due to an early departure**. INITIAL_____

All advanced fees paid will be refunded in full if notice is received in the CLC office fifteen (15) days prior to the applicants' session. If less than fifteen (15) days notice is received, all but the deposit will be refunded. If the applicant has not paid the deposit, the applicant will be billed. INITIAL_____

CHECK-IN: is **Friday** between the hours of **3:30 p.m. and 6:30p.m**. A parent/caregiver or other authorized person will be required to assist the camper during the entire check-in process. INITIAL_____

CHECK-OUT: is SUNDAY by 11:00 a.m. for all campers. There will be a $75/hour fee charged for all late pickups. Please plan accordingly. INITIAL_____

I understand that upon receipt of a medical report, a review of the report by the CLC Camp Nurse and/or Director may result in the cancellation of the camper's session due to unforeseen circumstances. In the event this occurs, you will be contacted directly by the appropriate CLC Staff.

Signature_____ **Date**_____

CAMPER QUESTIONNAIRE

The care of the camper depends on information provided on this form. Please answer all questions to the best of your ability and please be specific on any details that will be helpful in caring for the needs of the camper. This questionnaire must be completed before an acceptance letter can be sent.

Primary Diagnosis: _____ Secondary Diagnosis: _____

Approximate functional age level: _____

ALLERGIES: List ALL types, food, drug, environmental, etc.:

Allergy	Symptoms	Treatment

Does the camper have an allergy that requires an Epi-pen? _____

Behavior/Social Interaction *(please check all that apply or have occurred within the past year)*

	NO HISTORY		Destructive		Self Abusive		Inappropriate Sexual Behaviors
	Upset easily		Physically Aggressive		Invades Space		Sexually Aggressive
	Pulls Hair		Threatens		Wanders/Runs Away		Sexually Passive
	Hits/Scratches others		Curses/Verbally Abusive		Screams		Other:
	Bites		Lies of Steals		Bangs Head		

How often do these behaviors occur? (Please circle) *Seldom* (1X or less per month) Often (1X or less per week) *Frequently* (more than 1X per week) *Daily*

Does the camper have a safety plan or behavior management plan in place? (If yes, please submit copy with application)

_____

Please describe in detail these or any other challenging behaviors we should know about:

_____

Do you have specific ways or use "key phrases" for handling behavior?

_____

What usually triggers challenging behavior?

_____

During the past year, has the camper seen or is currently seeing a professional to address mental/emotional health concerns?
Yes ( ) No ( ) If yes, please give a brief plan of care camper is following:

_____

Has the camper had a significant life event (death of a loved one, family change, group home change, trauma, etc) that has occurred in the last year? Yes ( ) No ( ) If yes, please specify and give additional detail as needed:

_____

Has the camper ever attended camp before? ( ) YES ( ) NO If yes, name of camp:_____

What hobbies/activities/interests does the camper enjoy doing? _____

Does the camper have any fears? _____

Toileting/Showering & Dressing *(Please check all that apply)*	Independently	With Verbal Cues	Some Assistance	Total Assistance
Uses Toilet* (see below)				
***We understand that toileting accidents occur.** Please circle frequency: Never Rarely Occasionally Frequently *** Campers must be continent. Depends are okay, but the camper must be able to change and clean up without assistance.** *** Staff is unable to assist with wiping.**				
Menstrual Care				
Shampooing/Soaping				
Showering				
Hair Care				
Misc. Ointments, Eye Drops, etc.				
Sun screen				

MEDICATIONS: (TO BE FILLED OUT BY PARENT/CAREGIVER/AGENCY)

All medication must be pre-poured in a med-minder box and the original bottles with one pill in the original container and/or bubble pack with
remaining pills (this includes vitamin supplements) must be brought to camp for pill verification.

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and non-prescription medications, dietary supplements, and homeopathic remedies. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**
Any changes in how the medication is given or in a dose that differ from those on the bottle must be verified by a physician in writing or the healthcare staff **WILL REFUSE** to administer it.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ - Camper takes no medication

☐ - Camper takes daily medication as follows: **standard camp medication times are listed in the chart below.**

Please complete the chart with accurate and current medication information

MEDICATION SHEET

PLEASE PRINT CLEARLY - "SEE ATTACHED" WILL NOT BE ACCEPTED

Any attachments must clearly state the medication, dosage, and reason for use and the time meds must be given.

Medication	Dosage	Reason for Use	8:00am Breakfast	12:00pm Lunch	3:00pm	5:30pm Dinner	8:30pm Bedtime	Other

Does the camper experience any side effects from the above medications? ( ) YES ( ) NO If yes, please explain

_____

The health history is correct, to the best of my knowledge, and the applicant has permission to engage in all activities, except as noted. Exceptions:

_____

PERSONS CHECKING-IN CAMPERS must be able to answer questions regarding camper's medication, special diets, and medical equipment.

If there is a change in the participant's health or medications, or if they have had surgery within 3 weeks prior to arriving at camp, PLEASE contact the Executive Director at (719) 687-2087 to determine if we are able to care for this participant.

By signing this application, I agree that the information included throughout is complete and true to the best of my knowledge. If there are any changes to medication or condition of the participant I agree to notify Colorado Lions Camp at least 2 weeks prior to camp session the participant will be atteneding

_____

Date: _____/_____/_____

ALTITUDE AWARENESS DISCLOSURE

Has the camper attended the Colorado Lions Camp before? _____
Where are you coming from? _____
What is the elevation?_____
Are you aware of the risks of traveling to a higher altitude and elevation?_____
Has the camper experienced altitude sickness in the past?
_____

Does the camper have any of the following pre-existing medical conditions? (Please check all that apply)

	High Blood Pressure		Heart Disease		Emphysema
	Arrhythmias		Congenital Heart Problems		Migraines
	Heart Failure		Pulmonary Hypertension		Strokes
	Asthma		COPD		Seizures
	Other: Be Specific:				

PLEASE READ AND INITIAL

PRE-EXISTING MEDICAL CONDITIONS AT ALTITUDE	INITIAL
HIGH BLOOD PRESSURE: It is not uncommon for lowland visitors with a history of HBP to experience temporarily high blood pressure at high altitude. This occurs even if you are on blood pressure medication and have well controlled blood pressure at sea level. A small percentage of these people will have unusually unstable blood pressure. HBP at altitude usually returns to your baseline blood pressure after 1-2 weeks of altitude. Some persons with HBP, however, develop lower blood pressure on ascent to high altitude. You generally do not need to change your blood pressure medication dosage. Increasing your dosage could result in dangerously low blood pressure upon returning to low altitude. If you are having symptoms from your high blood pressure such as headache, dizziness, chest pain, or shortness of breath, you should seek medical treatment. Persons with difficult-to-control blood pressure can use oxygen, especially at night, to avoid problems.	
HEART DISEASE (Coronary Artery Disease): Altitude creates some stress on the heart, which is minimal at rest but can be significant during exercise. Reduce your exercise at high altitude to a bit less than you exercise at low altitude, especially the first few days. Stay on your regular medications. Spend an extra 1-2 days acclimating and avoid altitude sickness.	
ARRHYTHMIAS: PVCs or premature ventricular contractions occur frequently at altitude. The heart throws an extra beat every so often and while they are quite harmless, they can be uncomfortable. Avoidance of caffeine may help. Many patients with irregular heart rhythms, such as supraventricular tachycardia (SVT), or atrial fibrillation (a-fib) travel safely to altitude every year. Irregular heart rhythms should be in good control before going to high altitude.	
CONGENITAL HEART PROBLEMS: Persons born with heart problems such as ventricular septal defect (VSD), atrial septal defect (ASD), patent ductus arteriosus (PDA), or tetralogy of Fallot that is partially corrected may experience increased symptoms at altitude. These conditions may predispose to HAPE. As the blood pressure in the lungs rises, normal blood flow through the heart may get pushed through these holes in the heart in what is called right to left shunting. This potentially contributes to altitude symptoms as there is less blood getting loaded with oxygen in the lungs. Caution should be exercised when considering high altitude exposure in people with these issues. Use of oxygen at high altitude will prevent any problems.	
HEART FAILURE: Heart failure (HF) has not been studied extensively at altitude. Persons with HF have increased sensitivity to fluid retention. Since retaining fluid at altitude occurs frequently with or without AMS, this could potentially cause a worsening of heart function. Patients with HF, if they are careful, can likely travel to moderate altitudes safely.	

PRE EXISTING MEDICAL CONDITIONS AT ALTITUDE	INITIAL
PULMONARY HYPERTENSION: This condition of high blood pressure in the lungs can occur from many causes. Since high blood pressure in the pulmonary vessels is a main mechanism that leads to HAPE, persons with pulmonary hypertension have a much higher risk of developing HAPE and need to consider this risk before coming to altitude. The risk should be discussed with the physician. One approach is to use supplemental oxygen during the altitude stay, which will alleviate concern for any problems.	
ASTHMA: Persons with asthma do better at high altitude, contrary to some opinions. If one suffers allergic asthma, they do better at altitude than at sea level. As always, any asthmatic should continue their asthma medications and carry a relief inhaler with them at altitude just as they would at sea level or lower elevation.	
COPD/EMPHYSEMA: Patients with chronic lung disease have difficulty transporting oxygen from their lungs to their bloodstream. Visiting moderate altitude for those with emphysema may be feasible. Testing blood oxygen levels at low altitude in these people may help give us a better picture of who will do okay at altitude. Those with emphysema who wish to visit high altitude should visit their doctor to optimize their condition and may want to consider additional oxygen while visiting high altitude. Oxygen at high altitude will help anyone with lung disease and is easily available.	
MIGRAINES: Persons with migraine headaches are not at increased risk of altitude illness. IF a migraine develops at high altitude, however, it might be difficult to distinguish this from an altitude headache, although altitude headache does not have an aura and is not unilateral. A recent study suggests that low oxygen levels can trigger migraines. If you suffer from migraines, you should use your regular migraine medication at altitude if your headache seems like your typical migraine. If your medication is not effective, then you may need oxygen in addition to other treatments, as your headache may be due to AMS.	
STROKE/TIA: Occasionally, stroke-like symptoms such as weakness on one side of the body or partial blindness have been reported in otherwise young healthy persons climbing at very high altitude. These symptoms resolve with oxygen or returning to lower altitude. If you or someone you know experiences these symptoms, you should seek medical treatment immediately. If you have had a prior stroke and you decide to go to altitude you should continue to take all your medications as directed by your doctor and consider limiting your activity at high altitude. Persons taking a blood thinner such as Coumadin or Plavix need to be careful to avoid trauma, because of the risk of increased bleeding when on the medications.	
SEIZURES: Persons with seizure disorder well controlled on medications do well at high altitude, and it is generally considered safe to travel to altitude with epilepsy that is controlled with seizure medications. High altitude may unmask a seizure disorder in someone who has never had a previous seizure. In addition, the stress altitude, usually in combination with other factors such as cold, overexertion, lack of sleep, may cause a single seizure in persons without any type of seizure disorder. Persons who have been on seizure medication in the past but who have discontinued it might want to consider taking it again for a high-altitude trip, especially a longer trip or if going to a very high altitude.	

I,_____ (Parent/Caregiver/Guardian) have read and understand the risks associated in travelling and staying at the Colorado Lions Camp for the duration of a week session (Thursday to Sunday for _____ (Camper Name).

These risks have been provided to me and I am choosing to allow_____(Camper Name) to stay and participate at the Colorado Lions Camp despite the associated risks.

_____

_____

Parent/Caregiver/Guardian printed name

Parent/Caregiver/Guardian signature

_____

Executive Director printed name

_____

Executive Director Signature

COLORADO LIONS CAMP
CAMPER SEIZURE ACTION PLAN
MANDATORY FOR ALL CAMPERS

Camper's Name:_____ **Date of Birth:** _____

SEIZURE INFORMATION

Please document Camper's Seizure Activity: (Please check the box that applies)

☐ **Camper has NO Seizure History or Activity**
(No need to complete this form. Please sign and date at the bottom)

☐ **Camper has Epilepsy or Seizure Disorder?**
(Please complete this form in its entirety and provide as much information as possible.)

Parent/Caregiver/Guardian:	**Home Phone:** **Cell:**
Treating Physician:	**Office Phone:**

Seizure Type	Length	Frequency	Description

DATE OF LAST SEIZURE: _____

SEIZURE TRIGGERS OR WARNING SIGNS:

_____

CAMPER'S RESPONSE AFTER A SEIZURE: _____

EMERGENCY RESPONSE: *Please Attach a copy of current* ***Seizure Protocol****, if available.*

A "Seizure Emergency" for Camper is defined as:_____

_____

_

Seizure Emergency Protocol (Check all that apply)

- ☐ Call 911 after _____ amount of time
- ☐ Does Camper have a VNS (Vagal Nerve Stimulation) device? Yes _____ No _____
  If Yes, implant date? _____
- ☐ Notify parent or emergency contact? Yes _____ No _____ If Yes, who? _____
- ☐ Does Camper have emergency medication for seizures? If Yes, what medication and how is it administered? _____
  _____
- ☐ Notify Doctor (Name and Contact Phone #) _____
- ☐ Other _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) Describe any special consideration or precautions:_____

Parent/Caregiver/Guardian Signature: _____ **Date**: _____

PARENT/LEGAL GUARDIAN/AGENCY AGREEMENT

REQUIRED – Signature of applicant, if legally represents self; parent, legal guardian or authorized agency Please read the following statements carefully and sign your name to each.

I hereby give consent for the camper named above, to participate in all Colorado Lions Camp sponsored programs and supervised activities.
I certify that the information on the application is true, accurate, and complete. CLC emphasizes safety first; however, participation in CLC programs has inherent risks that may result in injury.

ACCEPTANCE CONDITIONS The Colorado Lions Camp reserves the right to refuse to provide services to any individual if the camp staff determines that the individual cannot be provided with adequate support by CLC. These decisions are made on an individual basis, by the Executive Director and/or Nurse. Parents/Guardians/Agencies will be notified in the event of any serious injury or illness requiring more than basic first aid, or in the case of any significant incident or behavioral problem. The separate Camp Physical Examination Form which must be completed and signed by a licensed physician, must indicate that there is no evidence of any condition that might present health or safety risks to the camper, other campers or staff members.

Applications and Medical Paperwork must be submitted annually.
I agree to the acceptance conditions above. Should it become necessary for my camper to leave camp, or any Colorado Lions Camp function, for any reason, I will make provisions to bring the camper home. I hereby certify that to the best of my knowledge, all the information contained in this application is true and complete. I hereby authorize the release of any and all pertinent information regarding this camper to the Colorado Lions Camp. I agree to notify CLC of any changes that need to be made in this application before camp begins.
Name:_____
Signature:_____
Relationship to Camper:_____
Date:_____

ASSUMPTION OF RISK I, _____(Parent/Guardian/Agency), of _____(camper), who desires to participate in the activities offered and organized by the Colorado Lions Camp, hereby acknowledge that I am aware of potential, significant risks associated with participation in camp, including, without limitation, the risk of serious bodily injury or death. On behalf of myself, the agency, my spouse and my successors, I willingly assume such risks. By signing this document I am providing a clear, written expression of my agreement to assume all of the risks and dangers my camper may encounter at camp. Yes or No
Parent/Guardian/Agency:_____
PERSONAL PROPERTY I, _____(Parent/Guardian/Agency) recognize that the Colorado Lions Camp cannot accept responsibility for camper's personal property. To help eliminate losses, the undersigned ensures that all clothing is labeled with the camper's name and a list of belongings has been included in luggage. This includes clothing, bedding, personal care items, electronics and equipment. Yes or No
Parent/Guardian/Agency:_____

MEDICAL RELEASE I, _____(Parent/Guardian/Agency), authorize that in the event that an emergency should arise while _____(camper) is at, going or returning from, camp requiring medical or surgical care or treatment, the Colorado Lions Camp staff may select and designate nurses, physicians and surgeons to furnish such medial and/or surgical care as, in the judgment of a physician and/or surgeon holding a physician's certificate issued by the Board of Medical Examiners of the State of Colorado, may be needed and proper. I authorize the CLC staff to render any aid and assistance to my camper, and to administer medication to my camper. I authorize the camp medical staff to dispense medications. I agree that medications for life threatening conditions (e.g., Epi-Pen, inhaler), will be carried by a camp staff member and I authorize their use for my camper as needed. I agree to pay for any prescribed medication or treatment my camper may need. I release and absolve the Colorado Lions Camp, nurses, physicians and surgeons elected and designated by them, from any and all liability for their acts rendered in good faith. **Parents/Guardians/Agencies will be notified immediately of any treatment sought.**
Parent/Guardian/Agency Signature:_____

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MEDIA RELEASE

The Colorado Lions Camp uses photographs, images or recordings of campers for publication in brochures, email, website, Facebook, social media and various other media to promote services or to recruit volunteers and staff. The camper named above **MAY be included** in these promotional materials unless you contact the camp directly.

Yes or No

Parent/Guardian/Agency:_____

RELEASE OF INFORMATION

I authorize release of any medical information requested by representatives of local, state or federal agencies, insurance companies or other organizations as may be required for payment of claims.

Parent/Guardian/Agency

Signature:_____

ASSIGNMENT OF BENEFITS

If a Medicare patient, I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I request the payment of authorized benefits be made on my behalf. (Please Skip if **Not Applicable)**

Parent/Guardian/Agency

Signature:_____

NOTICE OF PRIVACY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, clients of the Colorado Lions Camp are entitled to the greatest degree of privacy possible. Colorado Lions Camp will strive to ensure that client information is used only for the authorized purpose as agreed to by the client.

Parent/Guardian/Agency

Signature:_____

RELEASE AND WAIVER

In consideration of the permission granted by the Colorado Lions Camp for_____ (camper) to participate in activities at camp I, _____ (Parent, Guardian, Agency), hereby agree to release and discharge the organization, its officers, agents and employees from all claims, demands, actions or causes of action, which the camper, his or her personal representatives, heir and next of kin may or might have against the Colorado Lions Camp, its officers, agents and employees on account of injury to or death of the camper, or damage to the property of the camper arising out of the camper's participation in activities at camp. I further agree to indemnify and hold harmless the Colorado Lions Camp from any loss, liability, damage or costs that may be incurred due to the acts of the camper using the camper's participation in activities at camp.

Yes or No

Parent/Guardian/Agency:_____

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Colorado Lions Camp
28541 HWY 67 North
Woodland Park, CO 80863

Phone (719) 687-2087
Fax (719) 687-7435
clcoffice@coloradolionscamp.org

FOR OFFICE USE ONLY:
Date Rec'd_____
Session _____

Camp Physical Examination Form

This form must be completed and signed by a Licensed Physician NOT by a parent or caregiver

We request this form or a copy of a physical dated no later than **12 months** from your camp date be received in our office at least **TWO WEEKS** prior to the scheduled vb camp session.

Name:_____**Date of Birth**
_____/_____/_____ **Male**_____ **Female**_____

Diagnosis:_____

Is any condition present, which may result in an emergency? Please describe:
_____

Allergies (Drug/Food/Environmental)? Epipen required?
_____

EXAMINATION COMPLETED BY DOCTOR

Height: Weight:	Mouth/Throat/Nose:
Pulse: BP: Temp:	Neck/Thyroid & Lymph Sys:
Hearing Loss: NONE PARTIAL COMPLETE Hearing Aids Worn? Cochlear Implant?	Nervous System/Reflexes/Gait/Sensations:
Vision Loss: NONE PARTIAL COMPLETE Glasses Worn? Contacts Worn?	Bringing to camp: CPAP or Oxygen (CIRCLE) DAY NIGHT (CIRCLE)
Cardiac:	GI Distress - upper - lower (please specify)
Lungs:	Headaches:
Abdomen:	Bedwetting:
Musculoskeletal:	Incontinence – Urinary - Fecal (please specify)
Back/Spine:	Respiratory/Asthma/Emphysema (please specify)
Skin:	Sleep Apnea/COPD:
Diabetic: Insulin: YES NO Frequency of glucose monitoring:	Seizures: Type: Frequency: Last:
Mobility	Uses: WALKER CANE WHEELCHAIR

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox _____ Measles _____
Mumps _____ MRSA _____ Shingles/Herpes _____ Strep Throat _____ Hepatitis _____
Frequent UTI _____ Frequent URI _____ Chronic Cough _____ High BP _____ Other _____

IMMUNIZATION HISTORY Please give dates (month/year) of immunizations and most recent booster dates:
(DPT) _____ MMR _____ Polio _____ Smallpox _____ Influenza _____
TB Test _____ Hepatitis b series _____ Tetanus _____ Type _____**(REQUIRED)**

***Campers ages 8-21 must attach a copy of the current immunization record. If records are unavailable, please send a statement to that effect. Statement "up-to-date" not acceptable.**

QUESTIONNAIRE

Is camper free from communicable diseases? YES/NO If no, please describe:
_____

How would you access the applicant's current health? GOOD FAIR POOR

Has the applicant been hospitalized or treated in the emergency room in the last year? YES NO If yes, please explain
_____

Is the applicant a carrier of Hepatitis B or C has he/she been exposed to Hepatitis B or C? YES NO Are there medical reasons to limit or restrict this individual from participating in the following camp activities: swimming, horseback riding, supervised ropes course, hiking, and archery? _____Any limitations?_____Is this applicant on medication? YES NO (Please see back of form)

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and nonprescription medications, dietary supplements, and homeopathic remedies.

Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician. All changes in medication prescriptions or dosages must be verified by a physician in writing or the CLC medical staff **WILL REFUSE** to administer it.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ - Camper takes no medication

☐ - Camper takes daily medication as follows: **standard camp medication times are listed in the chart below.**

Please complete the chart with accurate and current medication information. If the camper cannot adhere to these times, please indicate alternate times and why medication must be given at that time. Please indicate the number of tablets, capsules, amount of liquids, or puffs of inhalers, etc. in the box below the time medication is given.

MEDICATION SHEET
MUST BE FILLED OUT BY PHYSICIAN'S OFFICE STAFF ONLY
DO NOT WRITE "SEE ATTACHED"

Any attachments (for clarification) must clearly state the medication, dosage, and reason for use and the time meds must be given.

Medication	Dosage & # of pills, puffs, liquid	Reason for Use	8:00am Breakfast	12:00pm Lunch	3:00pm	6:00pm Dinner	8:30pm Bedtime	Other

Does the camper experience any side effects from the above medications? ( ) YES ( ) NO if yes please explain_____

May take over the counter medications, if necessary? YES / NO Initial _____

May we contact you if we need more information? YES / NO

Physician's signature: **(MANDATORY)**_____

Date _____

Physician's Name (Please Print) _____

Phone: _____

Name of Person Filling out Form and Title:_____

CAMP PHYSICAL – PAGE 2

Medication Sheet Continued if needed:

Medication	Dosage & # of pills, puffs, liquid	Reason for Use	8:00am Breakfast	12:00pm Lunch	3:00pm	6:00pm Dinner	8:30pm Bedtime	Other