

# KY Lions Youth Camp

**Camper Application**  
**July 2 – 6, 2018**  
**Application Deadline: June 1, 2018**

Which Camp are you applying for?  Blind/Vision Impaired Camp  Deaf/Hard of Hearing Camp  
Print in **Black Ink**. **ALL Information** must be completed for the approval of your application.

Camper's Name \_\_\_\_\_ Goes By: \_\_\_\_\_  
 Male /  Female

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

### Information for Grant and Fundraising Statistical Purposes:

Race:  Caucasian /  Hispanic /  African American /  Native American /  Other \_\_\_\_\_

Household Yearly Income \$ \_\_\_\_\_; Number of People in Household \_\_\_\_\_

**Female Guardian Name** \_\_\_\_\_  
 Mother  Grandmother  Other \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Male Guardian Name** \_\_\_\_\_  
 Father  Grandfather  Other \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

### People authorized to pick up camper during camp:

Has Camper spent the night away from home before?  No /  Yes

Has Camper attended KY Lions Youth Camp before?  No /  Yes If yes, when \_\_\_\_\_

Can Camper bring bedding to camp (a pillow with twin sheets and a blanket)?  No /  Yes

T-shirt Size: **Youth:**  Sm. /  Med. /  Lg. **OR** **Adult:**  Sm. /  Med. /  Lg. /  XL /  XXL

**Print** Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Complete the following for **BLIND/VISION CAMPERS**: Camper is  Totally Blind  Legally Blind  Partially Blind  
Corrected vision: \_\_\_\_/\_\_\_\_ Right eye \_\_\_\_/\_\_\_\_ Left eye Camper reads:  Braille  Large Print  Regular Print  
Does Camper wear glasses  Yes  No Contact Lenses  Yes  No

Complete the following for **DEAF/HARD of HEARING CAMPERS**: Camper is  Deaf  Hard of Hearing  
 Has Cochlear Implant  
Camper communicates  Speech Only  Sign Language & Speech  Sign Language Only  
Does child wear hearing aids?  Yes  No Right Ear - Serial # \_\_\_\_\_ Brand name \_\_\_\_\_  
Left Ear - Serial # \_\_\_\_\_ Brand name \_\_\_\_\_  
Type of hearing aid batteries \_\_\_\_\_ **Please bring extra batteries!**

**CAMPER PERSONAL ASSISTANCE & CARE LEVEL**

Camper requires assistance with:  Dressing /  Toilet /  Bathing /  Mobility  
Other? explain \_\_\_\_\_

Does the camper wet the bed?  Yes /  No Does the camper wear Pull-Ups to bed?  Yes /  No

Rate child's "Level of Care" regarding behavioral issues (circle a number): 1 2 3 4 5  
1 = rarely gets upset; follows instructions very well  
5 = extreme behavioral issues; angers easily; prone to fighting

**Comments or Special Instructions:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Photography:**

May pictures be taken of camper for his/her personal use?  No /  Yes

May pictures be taken of camper for camp album?  No /  Yes

May pictures be taken of camper for promoting KY Lions Youth Camp?  No /  Yes

**NOTE: We take no responsibility concerning photos taken by other campers.**

After Completing the **4 Page** Application, Please Mail To:

**KY Lions Youth Camp  
c/o Lions Camp Crescendo  
PO Box 607  
Lebanon Junction, KY 40150**

**Application Deadline Date: June 1, 2018**

**For Questions or Additional Information Contact:**

Holly Bryant (Camp Director)

Phone: (270) 407-3482

Email: holly.bryant@wky.edu

Billie Flannery (LCC Administrator)

Phone: (502) 264-0120

Email: wibblesb@aol.com

Camper's Name: \_\_\_\_\_  
*Please Print*

Staff Only:  
AM 12P 3P 5P BT PRN

# MEDICAL INFORMATION SUMMARY

**\*\*\* Attach a copy of insurance/medical card and recent photo\*\*\***

Name of who to call if medical question or concern: \_\_\_\_\_  
 Parent  Relative  Other: \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_

Back-up person to call if medical question or concern: \_\_\_\_\_  
 Parent  Relative  Other: \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_  
Insurance Provider \_\_\_\_\_ Policy/Card # \_\_\_\_\_

**Medical conditions:**

- ADD/ADHD     ODD     Depression     RAD     BiPolar Disease     Autism
- OCD     PTSD     Anxiety     Separation Anxiety     Asthma     CP
- HIV
- Other: \_\_\_\_\_

History of Seizures?  Yes  No

Current tetanus shot:  Yes  No

Does Camper Have Allergies  Yes  No  
Sensitivities: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Seasonal Allergies: \_\_\_\_\_

Does Camper Use an EPI Pen?  Yes  No  
Reaction: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Reaction: \_\_\_\_\_

**\*\*\*If camper requires an EPI-Pen, this must be brought with them to camp\*\*\***

List each medication that the camper should be on while at camp:

RX Name	Strength	Dose	AM	NOON	3PM	Supper	Bedtime
<i>Example: Concerta</i>	27 mg	1 tablet	✓				

*If more space needed attach additional sheet*

Rescue Inhaler     Nebulizer medication: \_\_\_\_\_

- Medicines must be in original container.
- Place medications in zip lock bag and write child's name (*last name first*) on the outside.
- Do NOT place more than one child's medication(s) in the same bag.
- **Morning medications must be given prior to coming to camp!**

Camper's Name: \_\_\_\_\_  
*Please Print*

### **CONSENT FOR NON-PRESCRIPTION MEDICATIONS**

*This consent allows appropriate camp staff to give child over-the-counter medications as needed.*

- |                              |                             |                     |                              |                             |                    |                              |                             |                      |
|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|----------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Acetaminophen       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ibuprofen          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Naprosyn             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tums                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Imodium            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emetrol              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chloraseptic Spray  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sudafed            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Benadryl             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sting Kill          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Caladryl, Calamine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hydrocortisone Cream |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aloe with Lidocaine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neosporin          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Desitin              |

Other over-the-counter medication that works well for the camper: \_\_\_\_\_

Special Instructions for prescription medication and/or over-the-counter medication administration:  
\_\_\_\_\_  
\_\_\_\_\_

### **Statement of Release & Authorization (Signature required for approval of application):**

1. I hereby agree to release and hold camp staff free and harmless for any claims, demands, or suits for damages from any complication that may result from the proper administration of the non-prescription medications I have voluntarily marked "yes" and the prescription medications the camper brought to camp with them.
2. I hereby agree to release and hold Lion's Camp Crescendo free and harmless for any claims, demands, or suits for damages from any injury and/or illness occurring during camp session.
3. In case of an EMERGENCY, where the child needs to be seen by a physician, I hereby give permission for the child to be transported to a medical facility for the purpose of conducting examination, ordering x-rays, administering tests and/or receiving EMERGENCY treatment. *(Bring a copy of DNR if applicable)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relative/parent       Foster Parent       Other: \_\_\_\_\_

<b>FOR OFFICIAL USE ONLY:</b>	<input type="checkbox"/> <i>DCBS Medication Administration Form Required</i>
1) Has the camper had their medications today?      ___No      ___Yes	
2) Medications: <input type="checkbox"/> Just enough <input type="checkbox"/> Entire supply	
<input type="checkbox"/> Not Enough – Plan for correction: _____	
3) Medicine reconciled?      ___No      ___Yes	
If not, discrepancy: _____	
	<b>Medical Information Reviewer Initials:</b> _____
4) New/acute injuries present at arrival?      ___No      ___Yes	
Describe: _____	
5) Arrival weight: _____ <i>(optional)</i>	
6) Physical check complete?      ___No      ___Yes	
	<b>Examiner Initials:</b> _____
<b>Adult Dropping off Child Initials:</b> _____	<input type="checkbox"/> Bus transport