Adult Camp

August 14 – 19, 2020

BAY CLIFF HEALTH CAMP

DESCRIPTION: Adult Camp is an outdoor, inclusive (adaptive) recreation program for adults with disabilities.

PURPOSE: To enrich the lives of adults with disabilities, through exposure to new and/or more in-depth inclusive (adaptive) recreational and traditional camp activities in a remote, outdoor environment.

PROGRAM:
Daytime – Activities will include biking, boating & fishing, crafting, Dutch-oven cooking, hiking, kayaking, Lake Superior time (beach, swim, fire), tennis and others.
Evenings – introductions, make & bake pizza, bonfire, food/recipe competition, evening recreation, campout, lawn games, cookout, boat rides, costume competition and a hosted music night.

ELIGIBILITY: Criteria have been established to increase understanding of program limitations and promote safety for both campers/participants and staff. Applicants must first meet eligibility criteria as outlined (see reverse) to be accepted to participate in Adult Camp. To attend, participants/campers must also have a physical examination, which 'clears' them medically.

DATES: *Adult Camp* will take place from **Friday, August 14 - Wednesday, August 19** at Bay Cliff Health Camp's campus in Big Bay, Michigan.

COST: The cost per camper for the duration of Adult Camp is approximately $1,000.00. To promote enrichment of life and support attendance for those eligible and interested, Bay Cliff scholarships the majority of that cost. Campers/participants pay $300.00 to attend (paid during intake/registration).

Please return completed application via email or posted mail:
BAY CLIFF HEALTH CAMP
Attn: Adult Camp
PO Box 310
Big Bay, MI 49808

tcampana@baycliff.org
Subject: Adult Camp Application – Last Name, First Name (of applicant)

Call or email with any questions: ***Theresa 'Tree' Campana,*** (906)345-9314 ext. 256 or tcampana@baycliff.org

Adult Camp
ELIGIBILITY CRITERIA

BAY CLIFF HEALTH CAMP

GENERAL ELIGIBILITY

- Interested in attending and participating in an outdoor adaptive recreation camp program
- Safe in outdoor setting, situated on bluff with access to Lake Superior
- 18+ years old
- Have documented disability
- Meet the following requirements: established to understand limitations of staff training (one day) and program

PHYSICAL REQUIREMENTS

- Is in acceptable health indicated and established by physical examination
- No communicable disease present
- Safe/no risk to health in camp environment – germ exposure, smoke exposure, cold air, damp air, outdoors
- When completing a typical transfer, no more than minimal assistance required
- If applicable
    - Stable medications for behavior management
    - Seizures controlled by medication
    - Have established swallowing/dysphagia protocol

INTERPERSONAL REQUIREMENTS

- Can communicate yes/no, a choice, and information required to have basic needs met – verbally or through other means
- No recent violence/aggression toward self, others or property
- Not a danger to self or others
- Able to readily adapt to camp routine without disruption to the group environment. This includes but is not limited to:
    - Following directions given by staff
    - Living in a community/space with others
    - Participating in meals without disrupting others
    - Remaining with the group as required

Call or email with any questions: ***Theresa 'Tree, Campana,*** (906)345-9314 ext. 256 or tcampana@baycliff.org

IDENTIFYING INFORMATION
ADULT CAMP 2020

BAY CLIFF HEALTH CAMP

ELIGIBILITY INFORMATION:

I have read Bay Cliff's Adult Camp eligibility criteria and certify that:

- ☐ I/Applicant is interested in attending and participating in adult camp programming
- ☐ I/Applicant is safe in setting as described
- ☐ I/Applicant meets the physical requirements
- ☐ I/Applicant meets the interpersonal requirement

Signed: _____ Date: _____

(Printed): _____ Relationship to applicant (circle): Self / Guardian

BASIC INFORMATION:

Name (Last, First): _____

Street Address: _____

City/State: _____ Zip Code: _____

Phone #: _____ Email Address: _____

Birthdate: _____ Gender: _____ Medical diagnosis/es: _____

_____

Describe disability (how affected): _____

_____

GUARDIAN INFORMATION (IF APPLICABLE):

Name: _____ Relationship to Applicant: _____

Phone #: _____ Email: _____

Address: _____ City/State/Zip: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to applicant: _____

Phone #: _____ Email: _____

Address: _____ City/State/Zip: _____

MEDICAL INFORMATION:

Name of physician (PCP): _____ Phone:_____

Address: _____

Insurance coverage provider: _____

_____Group number: _____

*Include a copy of both sides of insurance card with application.

Call or email with any questions: ***Theresa 'Tree' Campana,*** (906)345-9314 or tcampana@baycliff.org

RELEASES
ADULT CAMP 2020

BAY CLIFF HEALTH CAMP

INDEMNIFYING RELEASE:

In consideration of the admission of this applicant to Bay Cliff Health Camp's Adult Camp, we hereby waive any and all claims, liability or demands, which we may hereafter acquire against Bay Cliff Health Camp, a Corporation, and against any and all of its officers, directors, and staff arising from or alleged to have arisen from the treatment, care, transportation, and entertainment of said camper while at its said camp in Big Bay, Michigan, and we do hereby indemnify Bay Cliff Health Camp and its officers, directors, and staff and agree to hold them safe and harmless from any and all claims, demands, liability, cost, and expense by or to any person or persons whatsoever arising or occurring as aforesaid.

IN WITNESS WHEREOF we have hereunto executed these presents this _____ day of _____, 20_____.

Signed: _____Witness: _____

INFORMATION AND MEDIA RELEASE:

Permission is hereby given to hospitals, clinics, rehabilitation centers, and physicians to release records to Bay Cliff Health Camp.

Permission is hereby given for the use of photographs and/or video of applicant recorded during Bay Cliff Health Camp events for Bay Cliff Health Camp print media, the Bay Cliff Health Camp website, Bay Cliff Health Camp social media, and visiting external media outlets for educational and promotional purposes by Bay Cliff Health Camp.

Signed: _____ Date: _____

AUTHORIZATION FOR MEDICAL CARE:

I hereby affirm that I am the applicant or legal guardian of the above named applicant and that the information contained in this application is correct and complete as far as I know. The applicant has permission to engage in all camp activities, including field and bus trips off the camp property, except as noted by me and examining physician. In the event of an emergency, I hereby give permission to the attending physician to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for the camper applicant. Permission is hereby given to *U.P. Health System – Marquette* to admit and authorize emergency treatment for applicant. I also authorize the Bay Cliff Health Camp medical staff to administer injections, medications, and drugs as prescribed by the attending physician to the camper applicant. I fully understand that Bay Cliff Health Camp does not provide health or hospitalization insurance. Any cost incurred for prescriptions, laboratory tests, and/or hospitalizations will be paid for by myself or my insurance.

I also give consent to the medical and nursing staff at Bay Cliff Health Camp to perform routine, non-surgical medical care at the camp health cottage, including treatment of minor cuts, abrasions, and the administration of over the counter medications, in accordance with standing orders and policies approved by the camp physician.

Signed: _____ Date: _____

(Printed): _____

DAILY LIFE INVENTORY

Applicant Name: _____

BAY CLIFF HEALTH CAMP

A. BATHING, DRESSING AND GROOMING

Directions: If applicant is independent and no adaptations are needed – check the top box in each column to indicate, and proceed to following number.

1. Bathing: What assistance/adaptations does applicant require to safely and thoroughly bathe?

☐ Independent	☐ No adaptations
☐ Set-up / Temperature Assistance	☐ Grab bars
☐ Prompts - Please specify: _____ _____	☐ Shower seat – type/s: _____ _____
☐ Physical Assistance - Please specify: _____ _____	☐ Handheld showerhead
☐ Dependent	☐ Other: _____

Bathing challenges/difficulties expected in camp environment? YES / NO. If YES, please specify: _____

_____

2. Dressing: What assistance/adaptations does applicant require for success in dressing?

☐ Independent	☐ No adaptations
☐ Set-Up / Weather Appropriateness Assistance	☐ Adaptive clothing – please specify:
☐ Prompts - Please specify:	☐ Adaptive dressing equipment – please specify:
☐ Physical Assistance - Please specify:	☐ Avoid certain closures – please specify:
☐ Dependent	☐ Other:

In what position is applicant able to get dressed with greatest independence? _____

Dressing challenges/difficulties expected in camp environment? YES / NO. If YES, please specify: _____

_____

3. Grooming: What assistance/adaptations does applicant require for success in grooming (deodorant, hair, teeth, face etc.)?

☐ Independent	☐ No adaptations
☐ Set-Up / Mirror / Visual Aide	☐ Specific Toothbrush:
☐ Prompts - Please specify:	☐ Specific tool/item – Please specify:
☐ Physical Assistance - Please specify:	☐ Grasp support – Please specify:
☐ Dependent	☐ Other:

Dressing challenges/difficulties expected in camp environment? YES / NO. If YES, please specify: _____

_____

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DAILY LIFE INVENTORY

Applicant Name: _____

BAY CLIFF HEALTH CAMP

B. COMMUNICATION

If primary communication is verbal, please complete the following:

What % (approximate) of this applicant's speech would a new/unfamiliar person be able to understand? ___

If 100%, continue section **G.** If less than 100%, complete the following: What concepts/words are difficult for applicant to communicate? _____

_____

If primary communication is not verbal (gesture, device/tool, ASL), please complete the following:

How does applicant communicate 'YES'? _____

How does applicant communicate 'NO'? _____

What additional messages/concepts is applicant able to communicate? _____

_____

_____

What type of device/tool does applicant use (if applicable)? _____

Does applicant have difficulty making a choice? YES / NO If YES, what support do they require, for success? _____

_____

How often is applicant able to complete a familiar request/direction (ex. close the door)? 0%-----50-----100%

C. FEEDING/EATING

1. Assistance and adaptations at mealtime – Check all that apply to applicant at a typical meal:

☐ Independent during meals	☐ No adaptations
☐ Needs assist after tires/fatigues	☐ Adaptive cup - Type: _____
☐ Needs set-up	☐ Adaptive utensil - Type: _____
☐ Needs food in bite-size pieces	☐ Adaptive plate - Type: _____
☐ Occasionally needs help with: _____ _____	☐ Other Adaptation: _____ _____
☐ Needs to be fed _____% of a typical meal	☐ Straw

2. Chewing and Swallowing: Is applicant able to safely consume food orally (by mouth)? YES / NO
Does applicant have any difficulty chewing or swallowing? YES / NO. If YES, please specify: _____

_____

Does applicant have any restrictions or alterations to their diet (swallowing/dysphagia protocol)? YES / NO
If YES, please specify: _____

_____

3. Positioning/Support: Can applicant eat safely on a bench or stool, with no back support? YES / NO (if YES, move to next box). What does applicant sit on while eating at home? _____

If applicant is wheelchair user, are they able to pull up to average height (28-30") table? YES / NO. If NO, what position/what setup are required? (ex. from tray table, in wheelchair) _____

_____

DAILY LIFE INVENTORY

Applicant Name: _____

BAY CLIFF HEALTH CAMP

4. Any interpersonal challenges for applicant at mealtime? _____
Do you foresee difficulties for applicant participating in a group eating environment, where traditional manners are emphasized? YES / NO If YES, please specify: _____
_____

D. INTERPERSONAL

1. When something unexpected happens, how does applicant react? _____
_____
When upset, what support does applicant need to calm down? _____
_____
What support does applicant need to be successful during a new/novel experience? _____
_____

2. Group living: participants live in cabins with 4-6 other people for the duration of the program, move around as a group and complete activities with many other people. Do you forsee any difficulties for this applicant with any aspect of group living? YES / NO. If YES, please describe: _____
_____
_____

The information addressed in this section is sensitive. This information is important for us to provide a successful and safe program for participants. Concerns with/for applicant related to:

☐ Fighting	☐ Impulsivity	☐ Personal space boundaries	☐ Abuse
☐ Quick to anger	☐ Sexual behavior	☐ Violence/aggression toward others	☐ Suicidal ideation or attempt/s
☐ Inappropriate verbal expression	☐ Public masturbation	☐ Self-harm	☐ Property Destruction

Notes/Additional information: _____
_____

3. **MOBILITY**

Primary method of mobility *indoors*: _____
Primary method of mobility *outdoors* (if different): _____

Check boxes that apply to applicant regarding their level of independence and adaptations for mobility:

☐ Independent	☐ No Adaptations/equipment
☐ Modified Independent (equipment used, but no supervision needed)	☐ Orthotics/Braces – please specify type: _____ _____
☐ Supervision	☐ Forearm crutches
☐ Arms-Length supervision	☐ Walker
☐ Prompts – please specify: _____ _____	☐ Cane
	☐ Manual Wheelchair
☐ Assistance – please specify: _____ _____	☐ Power Wheelchair
	☐ Other: _____

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DAILY LIFE INVENTORY

Applicant Name: _____

BAY CLIFF HEALTH CAMP

Bed Mobility: Is applicant able to independently get into and out of their bed? YES / NO
If NO, please describe the assistance they require: _____

_____

Is applicant able to move independently in bed for their comfort (roll, shift etc.)? YES / NO
If NO, please describe the assistance they require: _____

_____

Transfers: moving from one surface to another.
Circle level of independence during typical transfer:
Independent Supervision Stand-By Assist Contact Guard Assist Minimum – Moderate Assist

Describe transfer method used (position, tips etc.): _____

_____

_____. *To promote safety for participants and staff –due to the short duration of training- we are not able to support participants who require maximum assist during transfers, dependent transfers, two-person assistance or Hoyer lifts.*

4. SLEEP

Typical, twin-size beds (wooden bunk-bed style) are provided for participants and staff to sleep on.
Does applicant typically require assistance during sleeping hours? YES / NO. If YES, please specify: ___

_____

Sleep challenges/difficulties expected in camp environment? YES / NO. If YES, please specify: _____

_____

5. TOILETING / CONTINENCE / PERSONAL HYGIENE

Directions: Check all boxes that apply to applicant, and include additional information if indicated.

☐ No Assistance or prompts	☐ No equipment needed
☐ Reminders (wash hands, use toilet, schedule)	☐ Brief – please specify size: _____
☐ Assistance wiping	☐ Wipes
☐ Prompts – please describe: _____ _____	☐ Adaptive seating – please specify: _____ _____
☐ Assistance – please describe: _____ _____	☐ Catheters/adaptive toileting equipment – please specify:_____
☐ Dependent	☐ Seat Belt / Gait Belt

Toileting challenges/difficulties expected in camp environment? YES / NO. If YES, please specify: _____

_____

Feminine Hygiene - for menstruating females: does applicant require assistance/prompting to manage her period? YES / NO / N/A If YES, please specify: _____

_____

MEDICAL INFORMATION

BAY CLIFF HEALTH CAMP

Applicant's Name: _____

Medical Diagnosis/es: _____

Directions (MEDICAL INFORMATION section): Complete first four pages (7-10), attaching additional pages as needed. Have applicant's regular health care provider complete final two pages (11-12), and complete a physical examination. If applicant has had a physical exam in the past three months, you may request your health care provider to fill out the form without an additional visit. If applicant's most recent physical is more than three months past, they must complete a physical examination.

HEALTH HISTORY

Surgeries: Has applicant had surgery/ies? YES / NO Descibe:

A. **Illness/Injury/Accidents:** Has applicant had any serious illness, injury or accident? YES / NO
Specify:

B. **Abuse:** Has applicant been the victim of abuse? YES / NO Has applicant been abusive toward others? YES / NO If YES to either, please explain:

C. **Behavioral/Mental Health:** Has applicant received service/treatment from a counselor, psychiatrist or psychologist? YES / NO Is he/she receiving the service/treatment currently? YES / NO If YES, describe:

D. **Changes:** Has applicant had any recent medical changes (past 6 months)? YES / NO Any expected changes in the near future (next 6 months)? YES / NO If YES to either, please specify:

E. **Other:** Provide any additional important medical information about applicant:

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MEDICAL INFORMATION

BAY CLIFF HEALTH CAMP

Applicant's Name: _____

CURRENT (KEY) CONCERNS

Directions: Complete each section with **current** information. If you answer 'NO' to one CONCERN, you can move to following, unless otherwise noted.

A. Allergies: Does applicant have any known allergies? YES / NO

1. Food Allergies?
   Reaction:
2. Medicine/Drug Allergies?
   Reaction:
3. Environmental Allergies?
   Reaction:
4. Latex Allergy/Sensitivity?
   Reaction:

B. Baclofen Pump: Does applicant have a Baclofen pump? YES / NO
If YES, when placed? _____. Last / Next fill dates: _____/_____

Any issues? _____

C. Bladder/Bowel Habits: (review all before moving to next CONCERN)

1. Does applicant have a bladder or bowel program? YES / NO
   If YES, please specify:
2. Bowel habits:
3. Bladder habits:
4. Concerns/issues related to bladder/bowel habits?

D. Breathing: Does applicant have any difficulties breathing during the day or night? YES / NO

1. Does applicant have an inhaler? YES / NO
   Any challenges with current inhaler? YES / NO If YES, please specify:

   When is inhaler used?
2. Does applicant use a CPAP at night ? YES / NO If YES, any difficulties or tips for use:

E. Constipation: Does applicant ever have constipation? YES / NO

How often?
Effective treatment for constipation?

F. Diet: Does applicant have dietary restrictions or a special diet? YES / NO If YES, specify:

G. Equipment: Does applicant have equipment they use daily? YES / NO. If YES, describe:

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MEDICAL INFORMATION

BAY CLIFF HEALTH CAMP

Applicant's Name: _____

H. Falls: Does applicant have history of falls? YES / NO. If YES, when was most recent fall? _____

Cause of fall/s? _____

I. Glasses: Does applicant wear glasses? YES / NO

Glasses worn for: Issues with glasses?

J. Hearing Aid/Cochlear Implants: Does applicant wear hearing aids or cochlear implants? YES / NO.

Type: Issues with equipment?

K. Restrictions: Does applicant have any activity or movement restrictions? YES / NO

Why? What caused the restriction? Restricted activities: Restricted movement/s:

L. Seizures/Epilepsy: Has applicant ever had a seizure? YES / NO

1. Most recent seizure (type & date): _____
2. Currently? YES / NO
3. On medication for seizure management? YES / NO
4. Have a Vagal Nerve Stimulator (VNS)? YES / NO
5. Important information about applicant's seizures: _____

_____

M. Skin Issues: Does applicant have current or past skin breakdown? YES / NO. If YES, describe frequency and location/s: _____

N. Shunt: Does applicant have a shunt? YES / NO

1. Type of shunt:
2. When placed:
3. Last revision:
4. Any problems/concerns?

O. Urinary Tract Infections (UTIs): Does applicant have frequent UTIs? YES / NO

1. How often?
2. Most recent:
3. First symptom:

P. Other: Does applicant have other current medical concerns? YES / NO

Describe in detail:

Call or email with any questions: ***Theresa 'Tree' Campana,*** (906)345-9314 or tcampana@baycliff.org

MEDICAL INFORMATION

BAY CLIFF HEALTH CAMP

Applicant's Name: ____

MEDICATIONS:

Medication	Dose	Reason/Purpose	Time taken (circle all that apply)					
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN
			8AM	12PM	3PM	5PM	8PM	PRN

Medication routines (if unique/specific):

MEDICAL INFORMATION

Applicant's Name: _____

TO BE COMPLETED BY HEALTH PROFESSIONAL

Directions: Complete all sections of the form – 1. Immunization verification 2. Tuberculosis screening 3. Setting/Requirements 4. Physical exam. Initial each section and provide an authorizing signature (MD, DO, PA or DNP).

1. IMMUNIZATION VERIFICATION

Verify the immunization record for the above named applicant, check the appropriate box, and initial.

- ☐ All required immunizations have been given / are up to date.
- ☐ Has not received all required immunizations / immunizations are out of date.

INITIAL_____

2. TUBERCULOSIS (TB) SCREENING

Check each box that is accurate for the above-named applicant.

- ☐ Born in a high risk country (countries other than the United States, Canada, Australia, New Zealand or Western and North European countries)
- ☐ Traveled to high risk countries and had contact with the local population more than one week
- ☐ Has a family member with a positive skin test result
- ☐ Has a family member with tuberculosis disease

Review screening section and check whether TB testing is indicated or not. If indicated, Bay Cliff requires documentation of a negative test be provided for acceptance.

- ☐ Tuberculosis (TB) testing not indicated
- ☐ TB testing indicated

INITIAL_____

3. SETTING/REQUIREMENTS

Bay Cliff Health Camp's adult program is a week-long sleep away camp in wooded, remote Big Bay, Michigan. Participants live in cabins, spend much time outdoors and are exposed to rain, cold weather and smoke (fire) during the program.

To be eligible for Adult Camp, applicants must be:

- ☐ In acceptable health indicated and established by physical examination (next page)
- ☐ No communicable disease present
- ☐ Safe/no risk in camp environment from exposure to germs, smoke, damp and cold air
- ☐ Not a danger to self/others/property
- ☐ Able to readily adapt to camp routine/group living

INITIAL _____

Call or email with any questions: ***Theresa 'Tree' Campana,*** (906)345-9314 or tcampana@baycliff.org

MEDICAL INFORMATION

BAY CLIFF HEALTH CAMP

Applicant's Name: _____

Date of Birth: _____ Age: _____ Date of Exam: _____

PHYSICAL EXAMINATION

Height: Weight: BMI:

History & Diagnosis/es:

Temp: Resp:

Pulse: BP:

CODE: **W**: Within normal limits. **A**: Abnormal/problem area **NE**: Not examined

Are the following:	W	A	NE	Describe abnormal findings:
Skin/Hair/Nails				
Ears/Hearing				
Eyes/Vision				
Mouth/Throat/Teeth				
Nose/Head/Neck				
Lungs				
Heart				
Abdomen				
Genitourinary				
Extremities				
Back/Hips/Posture				
Neurological				
Behavioral				

Current applicable treatments:

- ☐ AAC Device
- ☐ Altered Texture Diet (Dysphagia level _____)
- ☐ Glasses / Contacts
- ☐ Hearing Aids
- ☐ Intrathecal Baclofen Pump: Last fill: _____ Next fill: _____
- ☐ Medication/s – behavior management
- ☐ Medication/s – seizures
- ☐ Mobility Aids
- ☐ Shunt – type: _____ Placement: _____ Revisions: _____
- ☐ Other – describe: _____ _____

Can this applicant safely participate in Bay Cliff's Adult Camp (as outlined on previous page)?

☐ YES ☐ *YES – with restrictions/precautions* ☐ NO

If ☐ *YES – with restrictions/precautions* selected, describe:

Dietary Restrictions:

Activity Restrictions:

Physical Precautions:

Other Restrictions/Precautions:

I have examined the above-named applicant and have reviewed their medical records. Statements and recommendations made are informed and accurate.

_____ Date: _____

(SIGNATURE & CREDENTIALS)

_____

(PRINTED NAME)

Call or email with any questions: ***Theresa 'Tree' Campana,*** (906)345-9314 or tcampana@baycliff.org