To our Families, Caregivers and Guests,

Thank you for your interest in attending Quest's Camp Thunderbird!

Our Application and Health Forms have been updated for the Summer 2017 Season.

Taking the time to complete these forms thoroughly helps ensure that we are able to plan for and provide excellent care for our guests—your loved ones! If you have additional information that you would like to share with camp team members to help us prepare for your guest, you may attach additional pages.

Our application and medical forms are detailed. If an applicable section is not complete, the packet will be returned to you for completion. Please indicate which of the guest's contacts is responsible for the completion of the application, so we can direct any questions to the appropriate person.

All pages of the application packet (including the physical signed by the doctor), two photos, and the deposit are required before guests will be approved to attend camp.

The physical requires both the doctor's signature and the parent/guardian's signature and should be dated within twelve months of the camp session.

Camp Thunderbird must be informed of any medication updates and changes to the guest's physical, emotional or behavioral health that occurs between the receipt of the application and the beginning of camp. This notification must be in writing (mail, fax or email).

When submitting the forms, please keep a copy for yourself. If anything is lost in the mail/fax/email, you will need to have a copy to resubmit.

If you have any questions, please email Camp Directors and our Camp Nurse at CampThunderbird@questinc.org.

Thank you for your help and we look forward to a fun and healthy camp season!

Camp Thunderbird

The Quest's Camp Thunderbird Team

Camp Thunderbird

Attach 2 Recent Photos Here (Mandatory)

Summer 2017 Application

Guest & Guardian Information

Guest Legal Name _____ Nickname _____

Address _____

City _____ State _____ Zip Code _____

☐ Check here if your address has changed from last summer. APD Client ◯ Yes ◯ No

County _____ Social Security Number _____

Phone _____ Email _____

Date of Birth _____ Age _____ Gender: ◯ Male ◯ Female

Employment _____

Residence: ◯ Family/Home ◯ Foster Home ◯ Independent Living ◯ Group Home _____

Diagnosis _____

Legal Guardian Name _____ Relationship to Guest _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Preferred method of contact for application questions: ◯ Email ◯ Phone

Emergency Contact while at Camp (if parent/guardian is not available in an emergency)

Primary Emergency Contact _____

Home Phone _____

Work Phone _____

Address _____

City _____ State _____ Zip Code _____

Secondary Emergency Contact _____

Home Phone _____

Work Phone _____

Address _____

City _____ State _____ Zip Code _____

Attended Camp Thunderbird before:

◯ Yes Number of years _____

◯ No How did you hear about us/Referred by _____

Abilities Assessment

No	Yes	
○	○	1. Run? _____
○	○	2. Walk three blocks without tiring? _____
○	○	3. Swim? _____
○	○	4. Follow simple directions? _____
		Does the guest:
○	○	5. Usually express needs verbally? _____
○	○	6. Only use single-word utterances? _____
○	○	7. Smoke cigarettes, cigars or a pipe? _____
○	○	8. Have any dietary needs or restrictions? _____
		Is the guest:
○	○	9. Responsive to people? _____
○	○	10. Continent during the day? _____
○	○	11. Continent at night? _____

Explain any restrictions to activity (e.g., what can't be done, what adaptations or limitations are necessary, etc.)

_____

_____

Activities of Daily Living Assessment

	No Assistance	Verbal Prompts	Partial Assistance	Total Assistance
Dressing	☐	☐	☐	☐
Hygiene/ Grooming	☐	☐	☐	☐
Bowel Routine	☐	☐	☐	☐
Bladder Routine	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Transfer to bed	☐	☐	☐	☐
Transfer to toilet	☐	☐	☐	☐

Additional Information

_____

_____

Supervision

○	General Supervision (5:1)
○	Close Supervision (3:1)
○	Requires 1:1 Supervision

Additional Information _____

_____

_____

_____

Behavioral Assessment

Is this the guest's first time away from home?

◯ Yes If yes, is homesickness likely? _____

◯ No

Is the guest: ◯ Outgoing ◯ Shy

Will the guest relate best to staff who are: ◯ Outgoing ◯ Quiet

How does the guest communicate? ◯ Talking (English) ◯ Signing ◯ Gestures

◯ Other _____

No	Yes	Does the guest have any history of:
◯	◯	1. Emotional or behavioral problems? (List possible causes/methods to improve behavior) ____
		_____
		_____
◯	◯	2. Admission to a facility due to emotional/behavioral problems in the last 12 months? _____
		_____
◯	◯	3. Hurting him/herself, others or property destruction? _____
		_____
◯	◯	4. Being extremely active, nervous or anxious? _____
◯	◯	5. Non-compliance? _____
		_____
◯	◯	6. Emotional outbursts? Type? Triggers? _____
		_____
		_____
◯	◯	7. Wandering away from a group? _____
◯	◯	8. Treatment for ADD or ADHD? _____
◯	◯	9. Difficulty sleeping? _____

Please include any additional information that will assist the staff in facilitating a successful camp session for your guest.

_____

_____

_____

_____

_____

_____

General Health Information

Please explain any "Yes" answer(s) below.

No	Yes	Has the guest ever:
○	○	1. Had any recent surgery, illness or infectious disease?* _____
○	○	2. Been hospitalized? _____
○	○	3. Had surgery? _____
○	○	4. Had a head injury? _____
○	○	5. Been knocked unconscious? _____
○	○	6. Had frequent ear infections? _____
○	○	7. Passed out during/after exercise? _____
○	○	8. Been dizzy during/after exercise? _____
○	○	9. Had chest pain during/after exercise? _____
○	○	10. Had seizures? _____
○	○	11. Had high blood pressure? _____
○	○	12. Been diagnosed with a heart murmur? _____
○	○	13. Had mononucleosis is the past 12 months? _____
○	○	14. Had an eating disorder? _____
○	○	15. Had emotional difficulties for which professional help was sought? _____
		Does the guest:
○	○	16. Have a chronic or recurring illness/condition? _____
○	○	17. Have frequent headaches? _____
○	○	18. Wear glasses, contacts, or protective eyewear? _____
○	○	19. Have orthodontic appliances he or she is bringing to camp? _____
○	○	20. Wear a helmet? _____
○	○	21. Have any skin problems (e.g., itching, rash, acne)? _____
○	○	22. Have diabetes? _____
○	○	23. Require blood sugar checks? _____
○	○	24. Use an insulin pump? _____
○	○	25. Have asthma? _____
○	○	26. Require a nebulizer or CPAP? _____
○	○	27. Have back problems? _____

General Health Information Questionnaire continued on next page.

No	Yes	
◯	◯	28. Have problems with joints (e.g., knees, ankles)? _____
◯	◯	29. Wear orthopedic braces? _____
◯	◯	30. Have problems with sleep walking? _____
◯	◯	31. Have abnormal menstruation history? _____
◯	◯	32. Have problems with diarrhea or constipation? _____
◯	◯	33. Have a history of bedwetting? _____

*Any changes between application and camp session must be reported to Camp Director or Camp Nurse prior to check in.

If you would like to explain any of your answers, use the lines below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Does the individual have any known allergies? ◯ No ◯ Yes (If yes, fill out allergy information below)

List of known allergies	Describe reaction and management of reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications & Treatments

List all medications, treatments, supplements, vitamins, etc… taken on a regular basis to improve or maintain health.

Submission Instructions:

1. Guests residing at home with their families or that live independently require:

    A. Complete Medication list (use chart below or attach a list that includes full name of medication, strength, dosage, time given and reason for taking).

    B. Follow Labeling Guidelines in the Medication Addendum

2. Guests residing in the Group Home require:

    A. Two pharmacy generated, typewritten Medication Administration Records (MARs)

        i. One MAR with initial application

        Ii. 2nd MAR should be **current** (within 30 days) at the time of camp

    B. All medications to be administered should be typed entries. Any handwritten entries **must** be accompanied by a prescription from an authorized prescriber (MD, DO, ARNP, PA…)

3. APD clients residing in a Group Home, independent living, supported living, foster home or other non-familial setting must submit a Pharmacy MAR (as detailed in Section 2).

*Medications are dispensed at the following times: **B**-breakfast (8:15am), **L**-lunch (1pm), **S**-snack (3:30pm), **D**-dinner (6pm) and **HS**-hours of sleep (8:30pm).

Medication Name/Strength	Dose/# of Pills	Time Given	Reason for Taking
Ex. Aspirin, 81mg	1 tablet	B	General/heart health

If dosage of medication is different that indicated on the package, a physician's signature is required below.

Signature of M.D. _____ Date _____

Guest Illness History

Has guest ever had:	No	Yes	Vaccinated
Measles?	◯	◯	☐
Chicken Pox?	◯	◯	☐
German Measles?	◯	◯	☐
Mumps?	◯	◯	☐
Hepatitis A?	◯	◯	☐
Hepatitis B?	◯	◯	☐
Hepatitis C?	◯	◯	☐
PPD Test	◯	◯	☐

Date of last test _____

Result ◯ Positive ◯ Negative

Guest Vaccination History

Please give all dates of immunization for each vaccine listed below.

Vaccine	Mo/YR	Mo/YR	Mo/YR	Mo/YR	Mo/YR
DPT					
TD (tetanus/diphtheria					
Tetanus					
Polio					
MMR					
or Measles					
or Mumps					
or Rubella					
Haemophilus influenza B					
Hepatitis B					
Varicella (chicken pox)					

By signing this, I acknowledge that the immunization information documented is true and accurate to the best of my knowledge.

Parent/Guardian _____ Date _____

Group Home Manager _____ Date _____

OR if your guest has not been fully immunized, please sign the following statement: I understand and accept the risks to the guest from not being fully immunized.

Signature of Custodial Parent/Guardian _____ Date _____

Relationship to Guest _____

Physician Contact Information

Primary Physician Name _____ Specialty _____

Phone Number _____ Address _____

City _____ State _____ Zip Code _____

Secondary Physician Name _____ Specialty _____

Phone Number _____ Address _____

City _____ State _____ Zip Code _____

Insurance/Medical Information

Medical Insurance—please attach a copy of the insurance card(s) with front and back views.

Is the individual covered by medical/hospital insurance? ◯ No ◯ Yes (If yes, fill out information below.)

Insurance Company _____ Policy Number _____

Phone Number _____ Address _____

City _____ State _____ Zip Code _____

Name of Policy Holder _____ Relationship _____

Physical Examination by Licensed Medical Professional (MD, DO, ARNP)

The section below must be completed by a **licensed medical professional** who has conducted a physical examination of the individual anytime within 12 months before he or she arrives at Camp Thunderbird.

I examined (full legal name of guest) _____ on (date of exam) _____

Blood pressure _____ Weight _____ Height _____

The applicant is under the care of a physician for the following _____

_____

Restrictions/recommendations at camp (if none, state "none") _____

_____

Medications to be administered (name, dosage, frequency—if none, state "none") _____

_____

The following nonprescription medications are used by the Camp Thunderbird nursing staff on an as-needed basis. Please select any items the individual **should not be given.**

- ☐ Acetaminophen (Tylenol)
- ☐ Pseudoephedrine (Sudafed)
- ☐ Dextromethorphan
- ☐ Chloraseptic (sore throat spray)
- ☐ Calamine lotion
- ☐ Hydrocortisone 1% cream
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Chlorpheniramine maleate
- ☐ Diphenhydramine (Benadryl)
- ☐ Lice shampoo
- ☐ Bismuth subsalicylate (Pepto)
- ☐ Topical antibiotic cream
- ☐ Phenylephrine (Sudafed PE)
- ☐ Guaifenesin
- ☐ Generic cough drops
- ☐ Scabies cream
- ☐ Laxatives (Ex-lax)
- ☐ Aloe

Known allergies? (If none, state "none") _____

_____

Additional Information _____

_____

_____

I have reviewed the health history form in its entirety and have conducted a physical examination. In my opinion, the applicant is able to participate in an active special needs camp program (except as noted).

Licensed Medical Personnel Signature _____ Date _____

Printed Name _____ Title _____

Address _____ Phone _____

Full office name or stamp _____

I have understood the licensed medical personnel's recommendations and restrictions (if any) for the guest.

Guest/Guardian Signature _____ Date _____

Lost and Found / Property Damage

LOST AND FOUND: We will make every effort to return lost items to their owners – but we are only able to do so if the item has a name and/or phone number on it. Label each piece of your guest's camp gear and clothing (including bags, backpacks, sleeping bags and pillows) with his or her first and last name.

If you mistakenly receive someone else's item, please contact Camp Thunderbird at 407.889.8088 to make arrangements to return the item to its owner. Parents/guardians are responsible for cost to mail/return said items. Quest, Inc. and Quest's Camp Thunderbird are not responsible for ANY lost, damaged or stolen items.

ITEMS LEFT AT CAMP At the end of each session, we will attempt to return lost and found items to guests before they leave camp. All lost and found items remaining at the end of each session will remain at Camp Thunderbird for two weeks. Call 407.8890.8088 to locate lost items. Two weeks after your guest's camp session ends, items will be donated to charity.

Items of extreme value or personal attachment should not be brought to camp as Quest is not responsible for their loss or damage.

Guests/guardians are responsible for any property destruction caused by the guest. **Initial here** _____

Authorization / Refund Information

I have read this application and give permission for (guest name) _____ to attend Camp Thunderbird. I understand that a guest may not be able to complete a full session due to incomplete or inaccurate information, and that refunds will be issued only if (a) we cannot accept someone; (b) the individual does not pass a physical evaluation; or (c) there is a documented illness, accident, death or emergency involving the individual or their immediate family member either prior to arriving at camp or during camp. **Initial here** _____

Guests will not be entitled to a refund if they leave camp because of (a) homesickness; (b) refusal to participate in scheduled camp activities; (c) a change in family plans; or (d) the guest's or legal guardian's desire to remove the individual from camp for reasons other than documented illness, accident, death or emergency, regardless of how long their stay was at camp. **Initial here** _____

If the camp director requests that a guest leave camp because of reasons including, but not limited to, the violation of regulations or procedures, or because of conduct that interferes with the health or well-being of the individual or others, no refunds will be issued. Failure to disclose behavioral or health concerns may result in dismissal without refund. **Initial here** _____

If a refund is approved, it can only be credited to the extent of the original payment. Awards or scholarships will be redistributed back to Camp Thunderbird. Refund requests will not be considered once the guest's session has ended. **Initial here** _____

I also give Quest, Inc. specific permission to use photographs that may be taken of this guest or in which they may be included with other people, in any form or type of distribution, either by themselves or with other photographs, unless specified below:

Completed by: ◯ Guest ◯ Parent ◯ Guardian ◯ Group Home Manager ◯ Other _____

Signature _____ Date _____

Authorization

This application and health history form is complete and correct to the best of my knowledge. I give (guest name) _____ permission to engage in all activities, except as noted. I give Camp Thunderbird permission to administer prescribed medication(s), over-the-counter medications and first aid; to seek medical treatment, including x-rays, hospitalization or tests as needed; and to provide nursing care while guest is at camp. I agree that Camp Thunderbird can arrange for necessary transportation related to medical needs. I agree to the release of any records necessary for treatment, referral or billing purposes.

Completed by: ◯ Guest ◯ Parent ◯ Guardian ◯ Group Home Manager ◯ Other _____

Signature _____ Date _____

Session Selection & Financial Information

***To receive early pricing for summer, *all information* must be received no later than March 1, 2017.** The complete application, deposit, 2 photos and optional financial aid form must be submitted with your application. Early bird discount is $50 off per 6-day session and $100 off per 12-day session.

Sessions	Stayover	Supervision
☐ Session 1: June 4—9, 2017 ($750)	☐ Stayover 1/2: June 9—11, 2017 ($300)	☐ Close Supervision ($50/day)
☐ Session 2: June 11—16, 2017 ($750)	☐ Stayover 2/3: June 16—18, 2017 ($300)	☐ 1:1 Supervision ($100/day)
☐ Session 3: June 18—29, 2017 ($1,500)	☐ Stayover 3/4: June 29—July 2, 2017 ($400)	
☐ Session 4: July 2—7, 2017 ($750)	☐ Stayover 4/5: July 7—9, 2017 ($300)	
☐ Session 5: July 9—14, 2017 ($750)		
☐ Session 6: July 23—28, 2017 ($750)		
☐ Session 7: July 30—August 10, 2017 ($1,500)		

_____ + _____ + _____ = _____

Session Fees | Stayover Fees | Supervision Fees | Total Camp Fee

Acceptance of Application & Forms

Completed forms can be mailed to Quest at 500 E. Colonial Drive, Orlando, FL 32803, faxed to 407.218.4304 or emailed to CampThunderbird@questinc.org. The camp does not confirm the receipt of each form and, instead, sends email alerts to parents if a form appears to be missing or incomplete as of the due date.

Did you remember to include:

☐ 2 guest photos ☐ Deposit ☐ Application (completed and signed)

☐ Optional Financial Aid form (Summer Camp due date is March 1, 2017)

- If you write a check for camp payment and it does not clear the bank for any reason, an additional fee of $35 per incident will be added to the amount due.
- Payment in full and all paperwork is due 30 days prior to the start of the camp session the guest plans on attending or admission to camp could be forfeited.
- A non-refundable deposit of $200 per 6 days of camp is due at the time of application.

Responsible for Payment: ◯ Guest ◯ Parent ◯ Guardian

◯ APD (District #) _____ Contact Name _____ Phone _____

FOR CAMP THUNDERBIRD USE ONLY: Date Received _____

_____ + _____ - _____ - _____ - _____ = _____

Session Cost	Special Needs Close ($50/day) 1:1 ($100/day)	Discounts	Scholarship	Deposit	**TOTAL DUE**