



ANDERSON WOODS CAMP

3966 Adyeville Road; Bristow, IN 47515
Camp: (812) 357-2325, Office: (270) 957-0260

RETURN APPLICATION TO: Anderson Woods, Inc.
3966 Adyeville Road; Bristow, IN 47515

PLEASE COMPLETE THIS FORM COMPLETELY AND CLEARLY IN BLACK INK. SPACES LEFT BLANK WILL REQUIRE RETURN OF YOUR APPLICATION FOR COMPLETION.

Name: _____ Age: _____
Date of Application: _____ County of Residence: _____
Address: _____ Zip _____
Date of Birth: _____ Sex: M / F Height: _____ Weight: _____ Home Phone: _____
Person(s) to contact in case of an emergency:
Name: _____ Phone #: _____ Relation: _____
Name: _____ Phone #: _____ Relation: _____
Name: _____ Phone #: _____ Relation: _____

What is Applicant's primary disability? _____
Secondary disability? _____ Cause of Disability? _____
Briefly summarize ability level of applicant: _____

Briefly describe any behavioral or emotional problems of applicant: _____

Is applicant his/her own legal guardian? ___ Yes ___ No If not, please list name of legal guardian: _____
Address: _____

Name & address of parent(s) if they are not legal guardian: _____
Phone: _____

Name of individual(s) that camper may be release to upon leaving camp: _____

(If unavailable at this time, please advise our Camp Director prior to pick up.)

Is this the applicant's first time at Anderson Woods? ___ Yes ___ No

Can applicant safely use an upper bunk bed? ___ Yes ___ No

If you have a preference for attending the same session as another camper, please state the name of the other camper: _____

Does the camper have any fear of animals? ___ No ___ Yes,
If yes, please specify: domestic? _____, Other (please specify) _____

DO NOT WRITE BELOW THIS LINE

◆.....◆
Application received: _____ Sessions requested: **1 2 3 4 5 6 7 8** Fee Paid: _____

Application complete _____ Incomplete _____ Returned for completion: _____

Date acceptance pack sent: _____ Bed assignment ___ U ___ L

Seizures _____ **Diabetic** _____ **Special Diet:** _____

Please complete the following information on _____ (Applicant's name)

NOTE: DUE TO THE TERRAIN WE ARE UNABLE TO ACCEPT ANYONE WHO MUST USE A WHEELCHAIR AND WE ARE A NON-SMOKING FACILITY.

In addition to non-ambulatory, there are a few other disabilities and/or behaviors that we are unable to accept. It is not our intention to decline anyone that we can possibly serve. The following information is intended to help us determine our ability to serve and enable our staff to be aware of and sensitive to the individual camper's needs.

ABILITY	YES	NO	ADDITIONAL COMMENTS
Can walk alone?			
Uses a cane?			
Uses a walker?			
Has normal hearing?			
Has normal vision?			
Is speech normal?			
Can talk, but difficult to understand?			
Uses sign language?			
Uses communication board/computer?			
Can communicate his/her personal needs?			
Can write by self?			
Can read?			
Can dress self?			
Can bathe self?			
Uses toilet unassisted?			
Needs regular toilet time?			
Has bladder control?			
Has bowel control?			
Wets bed at night?			
Uses shower without assistance?			
Can take care of personal belongings?			
Can eat completely by self?			
Needs food cut up but can feed self?			
Needs to be fed?			
Needs food blended?			
Needs a straw for drinks?			
Has difficulty chewing or swallowing?			
Has a food allergy? (Please list)			
Wanders away from camp?			
Cries, whines, screams frequently?			
Has temper tantrums?			
What usually causes them?			
Is extremely active?			

Please list any SPECIAL INSTRUCTIONS for any of the above listed needs: _____

Application completed by: _____	Date: _____
(Signature)	
Relationship to camper: _____	Phone # _____ Home Work _____

MEDICAL INFORMATION

Camper name: _____ D.O. B. _____
 Physician's name: _____ Phone: _____
 Physician's address: _____

In case of EMERGENCY, notify: (List three [3] contacts familiar with applicant)

1. _____ Phone #: _____ Relationship: _____
2. _____ Phone #: _____ Relationship: _____
3. _____ Phone #: _____ Relationship: _____

Will family/group home be out of town while applicant is at camp? ___ Yes ___ no If so, where can they be reached in an emergency? _____

Please check the following:	Yes	No	Additional					
			Type and frequency:					
Does the applicant have seizures?			Type and frequency:					
Is applicant diabetic?			Treated by Injections?	Yes	No	Self Administer?	Yes	No
Does applicant use a laxative?			Type?	How Often?		List times:		
Does applicant have any communicable disease/s			Type?	Type?		Type?		

PLEASE PROVIDE A CURRENT PICTURE OR PHOTO ID WITH THE APPLICATION.

CURRENT MEDICATION TO BE TAKEN AT CAMP

PLEASE SEND ONLY THE REQUIRED AMOUNT OF MEDICATION IN CONTAINER WITH THE CORRECT PHARMACY LABEL WITH THE CAMPER'S NAME AND THE NAME OF THE MEDICATION.

Name of Medication	Dosage	Time(s) given

Is it ok to give the following for pain relief or emergency? Tylenol ___ Yes ___ No;
 Advil ___ Yes ___ No; Benadryl ___ Yes ___ No

DIETARY RESTIRCTIONS: (List here any necessary dietary restrictions; list food allergies on page 2): _____

HEALTH	X	Date	ALLERGIES	X	Date	DISEASES	X	Date
Ear Infections			Hay fever			Chicken pox		
Rheumatic Fever			Poison Ivy, etc			Measles		
Convulsions			Insect stings			German Measles		
Diabetes			Penicillin			Mumps		
Nose bleeds			Other drugs			Asthma		

Indicate any operations or serious injuries recently incurred by the camper that the staff might need to be aware of: _____

Camper's special interests or hobbies: _____

