



**2025 Easterseals Oregon
Residential Summer Camp
Application**



Camper Name: _____ **Birth Date:** _____

Summer Overnight Camp Sessions

Easterseals Oregon is proud to offer two overnight camp sessions for children and adults living with disabilities. Each camp session offers five days and four nights with a supervision ratio of three campers per one staff member. This year, both sessions will be held at Evans Creek Retreat near Lyons, Oregon in July.

For more information, please visit www.or.easterseals.com/camping_recreation or call 503-228-5108

Choose Session

Non-Refundable Application Fee \$25.00

- | | | |
|---|---------------------------------|---------------|
| <input type="checkbox"/> Ages 18+ Sunday , July 13 – Thursday , July 17 | Evans Creek Retreat – Lyons, OR | Cost \$950.00 |
| <input type="checkbox"/> Ages 12-17 Sunday , July 20 – Thursday , July 24 | Evans Creek Retreat – Lyons, OR | Cost \$950.00 |

Are you planning to attend camp with a friend? Friends Name: _____

Bunk Request

- Bottom Bunk Top Bunk

COVID.

◆ I recognize that it may be required pre-camp to prove a negative Covid test, 14-day pre-camp temperature data, and proof of vaccination or written request for religious or medical waiver of vaccination.

Initial: _____

FIRE

◆ I understand that the September 2020 Beachie Creek Fire destroyed all Evans Creek’s buildings and the summer 2025 will be more rustic. There may be no buildings. There are yurts, covered areas for group gatherings and toilet, shower and handwashing facilities. There will be heat, ventilation, and air conditioning in the yurt accommodations.

Initial: _____

T-Shirt Size

One Camp T-shirt is provided, by Easterseals Oregon, to each camper. Please indicate size needed.

- Child** - SM MED LRG
Adult - SM MED LRG XL XXL XXXL

Camp Activities

Easterseals Oregon Summer Camp is the place to be for fun and making new friends. Campers choose from a wide range of activities. Please check activities of interest:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Arts & Crafts | <input type="checkbox"/> Drama/Skits/Puppetry | <input type="checkbox"/> Fishing | <input type="checkbox"/> Paddle Boating |
| <input type="checkbox"/> Stargazing | <input type="checkbox"/> Archery | <input type="checkbox"/> Hiking/Walking | <input type="checkbox"/> Dancing |
| <input type="checkbox"/> Music/Singing | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Nature Study |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Gold Panning | <input type="checkbox"/> Water Fight | <input type="checkbox"/> Bowling |
| <input type="checkbox"/> Puzzles/Games | <input type="checkbox"/> Mini-golf | <input type="checkbox"/> Horseshoes | <input type="checkbox"/> Tie Dye/Leather Craft |
| <input type="checkbox"/> Campfire Cooking | <input type="checkbox"/> Sleeping Outside | <input type="checkbox"/> RC Cars | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Listening to Stories | <input type="checkbox"/> Plant Care/Gardening | <input type="checkbox"/> Field Games | <input type="checkbox"/> Painting |
| <input type="checkbox"/> Drawing | <input type="checkbox"/> Wheelchair Swing | <input type="checkbox"/> Scavenger Hunt | <input type="checkbox"/> Creating Journals |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Swimming in River | <input type="checkbox"/> Horseback Riding | <input type="checkbox"/> Adventure Trail |
| <input type="checkbox"/> Ping Pong | <input type="checkbox"/> Air Hockey | <input type="checkbox"/> Foosball | <input type="checkbox"/> Making Friends |

Camper's favorite indoor activity at home: _____

Camper's favorite outdoor activity: _____

Other athletic activities: _____

PLEASE INCLUDE A PICTURE OF CAMPER WITH THE APPLICATION.

This confidential application must be completed in FULL. Incomplete applications will be returned and may delay processing for available spots.

Camper Information			
First Name:		Last Name:	
Mailing Address:			
City:	State/Zip:	County:	
Birth date:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Hm. Phone:	Cell:	Email:	
Group Home (if applicable):		Facility Director:	
Custody Status: <input type="checkbox"/> Independent <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____			
Insurance:	Policy #:	Group #:	
Medicare #	Medicaid #:	Social Sec. #:	
<input type="checkbox"/> Has previously attended Easter Seals Oregon Camp Date Last Attended: _____		<input type="checkbox"/> New to Easterseals Oregon	
Referral Source (if applicable): Name _____ Agency _____			
ODDS Services: <input type="checkbox"/> Camper Receives ODDS Services/Assistance <input type="checkbox"/> Camper is Eligible but does not receive ODDS Services/Assistance <input type="checkbox"/> Camper is ineligible to Receive ODDS Services/Assistance			
Parent(s) or Guardian Information			
First Name:		Last Name:	Relationship:
Hm. Phone:	Cell Phone:	Email:	
Hm. Phone:	Cell Phone:	Email:	
Address:		City/State/Zip:	
How do you prefer to be contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> US Mail			
First Name:		Last Name:	Relationship:
Hm. Phone:	Cell Phone:	Email:	
Address:		City/State/Zip:	
How do you prefer to be contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> US Mail			
If parents are divorced, who has custody during camper's time at camp?			
Is either parent or guardian currently or formerly employed by the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact - In case of emergency, the guardian will be contacted first. Please list two different emergency contacts in case the primary contact is not immediately available. These individuals MUST know the applicant and have permission to pick up applicant at camp, if needed.			
First Name:		Last Name:	Relationship:
Hm. Phone:	Cell Phone:	Work Phone:	
First Name:		Last Name:	Relationship:
Hm. Phone:	Cell:	Work Phone:	
Payment Information			
How do you plan to pay for camp? <input type="checkbox"/> Self Pay <input type="checkbox"/> Other Funding Source			
Describe other: _____			
If paying by any method other than Self Pay, please provide the following information to assist us in processing your payment. Please include a letter from your agency indicating approval of funding with your application.			

Funding Source Contact Information Agency Name: _____ Case Worker: _____	Email: _____ Phone: _____ Fax: _____
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Does the camper Receive or Qualify to Receive ODDS Funding or Assistance

Yes the camper qualifies and receive funding/assistance

Yes, the camper qualifies but does not receive funding/assistance

No, the camper does not qualify

Diagnosis Information **Camper Name:** _____

Primary Diagnosis:

Cognitive/Social Abilities – please check all that apply <input type="checkbox"/> Mental Disability (check one) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe & Profound <input type="checkbox"/> Learning Disability <input type="checkbox"/> Autism <input type="checkbox"/> Behavioral Disorder <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Attention Deficit Hyperactive Disorder	Physical Disability – please check all that apply <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Spinal Bifida <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Head Injury Visual: <input type="checkbox"/> Blind <input type="checkbox"/> Some Sight <input type="checkbox"/> Glasses Hearing: <input type="checkbox"/> Deaf <input type="checkbox"/> Some Hearing <input type="checkbox"/> Hearing Aids Other Physical Disability: _____
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Seizures: Grand Mal Petit Mal Other _____ VNS Yes No

Frequency _____ Duration: _____ Date of last seizure: _____

Camper Mobility: I = Independent MA = Minimal Assistance CA = Complete Assistance

Check one for each applicable area	I	MA	CA	Mobility Aids (List - walker, braces, crutches, etc.) Wheelchair required for long distances. <input type="checkbox"/> Yes <input type="checkbox"/> No
Walking				Wheelchair: <input type="checkbox"/> Manual <input type="checkbox"/> Power
Gross motor skills				
Mobility in wheelchair				Wheelchair transfer method: <input type="checkbox"/> Stand/Pivot <input type="checkbox"/> Non-weight bearing (2 person)
Wheelchair transfers				Comments/suggestions:

Personal Care Needs: I = Independent MA = Minimal Assistance CA = Complete Assistance

Cabin Care	I	MA	CA	Meal Time <i>Advise of all eating issues prior to arrival.</i>
Check one for each				Check one for each
Dressing				Appropriate portion taking
Brushing teeth				Cutting food
Washing hands/face				Food to mouth
Showering				Drinking from cup
Toileting				<input type="checkbox"/> Pureed food <input type="checkbox"/> Chopped food <input type="checkbox"/> Thickened liquids <input type="checkbox"/> # Calories _____ <input type="checkbox"/> Low Salt <input type="checkbox"/> Low Sugar <input type="checkbox"/> Special diet (please Explain): _____ <input type="checkbox"/> Special utensils: _____ <input type="checkbox"/> Problem foods: _____ <input type="checkbox"/> Chewing disorder/missing teeth <input type="checkbox"/> Dysphasia <input type="checkbox"/> Food restrictions: _____ <input type="checkbox"/> Other mealtime needs: _____
Female menstrual needs				
Bladder & Bowel Control				
<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Needs Reminders <input type="checkbox"/> Incontinent <input type="checkbox"/> Incontinent at night Schedule: _____				
Toileting Aids Used (please bring to camp)				
<input type="checkbox"/> Attends <input type="checkbox"/> Catheter - Type: _____ <input type="checkbox"/> Urinal <input type="checkbox"/> Other: _____				

Toileting comments/suggestions: _____

If your camper does NOT have dietary health needs & chooses to NOT eat camp food, caregivers are responsible for providing meals & snacks for the camper.

Sleeping

Awaken at night for restroom: _____ times
Difficulty (explain) _____
Needs bedrails Turned at night: _____ times
Has camper slept in a group environment? Yes No
CPAP Machine? Yes No
Sleeping comments/suggestions:

Allergies

Please list and explain all known food allergies: _____

Non-food allergies: _____

Describe reactions: _____

Supervision

Does camper require 1:1 total care and/or supervision?

Yes No
Explain: _____

Communication

Will camper clearly communicate wants/needs? Yes No
Reads Writes Sign Language Talks Gestures
Communication System Communication Comments/suggestions:

Medications:

Prescribed Medications: Yes No
Medication 1-2X daily:
Medications 3-4X daily:
Medication <4X daily:
Medication < 6 AM or > 10 PM:
Nebulizer:
Special Protocols: _____

Diabetic: Yes No

Diet Controlled:
Insulin Controlled:
Testing Time(s) _____
Average Blood Glucose _____

Fears:

Water Animals
Falling Dark
Height People/Crowds
Other: _____

Tobacco Products:

None:
Chews:
Smokes Tobacco Products:
Responsible for Smoking Safety
Describe Assistance/Monitoring: _____

Behavior: Please check any behavior patterns that apply

Happy-Go-Lucky Helpful Wanders Cautious Withdrawn/Shy Interacts well w/others Yells/screams

Physically aggressive, please describe: _____

Self-abusive, please describe: _____

Attention-seeking, please describe: _____

When do these behaviors occur? Is there a common trigger for these behaviors? _____

Suggest specific techniques for dealing with the camper's behavior: _____

physician approving that the camper is health appropriate for camp attendance. It is important that the physician list any and all restrictions and health precautions and current medications and treatments to be administered at camp. In the event a camper has a chronic negative health history, the health care personnel of ESO reserves the right to request additional information from the camper health care provider, including a physical before attending camp.

Camper/Guardian Signature _____

Date _____

Camper/Guardian Name Printed _____

Witness to Camper Signature _____

Date _____

Witness to Camper Name Printed _____

HIPAA COMPLIANCE

In compliance with federal guidelines (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT), this form **MUST** be on file prior to camp attendance and will remain active for seven years.

Camper Information: Name _____ (First) _____ (MI) _____ (Last) DOB _____

Notice of Privacy Practices:

I understand that Evans Creek Retreat LLC (hereafter referred to as ECR) and/or Easterseals Oregon (hereafter referred to as ESO) will use and disclose health information about me. I understand that my health information may include information received by ECR/ESO in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that ESO/ECR may use & disclose my health information in order to:

- make decisions about and plan for my care and camp activities with camp staff
- refer to, consult with, coordinate among, and/or manage with other health care providers involved in my care and for treatment in the event of illness or injury.
- determine my eligibility for camp attendance and/or particular camp activities
- perform various office and administrative functions that support ESO/ECO's efforts to provide me with best possible camp opportunities appropriate to my needs.

I understand that I have the right to receive and review the written description of how ESO/ECR will handle health information about me. This written description describes the uses and disclosures of health information made and the information practices followed by the staff and office personnel of ESO/ECR and my rights regarding my health information.

I understand that this description may be revised from time to time and that I am entitled to receive a copy of any revised practices upon request to ESO/ECR.

I understand that I have the right to ask that some and/or all of my health information not be used or disclosed in the manner described in the **Notice of Privacy Practice**, and I understand that ESO/ECR is not required by law to agree to such requests.

These releases are to be signed by a parent or legal guardian if participant is under 18 years of age **OR** by the participant if 18 or older **OR** if participant is legally emancipated.

Release forms and/or current likeness (photo) MUST be on file in office prior to attendance.

By signing below, I agree that I have reviewed & understand the information above.

Camper/Guardian Signature _____

Date _____

Camper/Guardian Name Printed _____

Phone _____

Camper Representative Signature _____

Date _____

Camper Representative Name Printed _____

Phone _____

Authority of Representative (Relationship) _____

Date _____