Duffield Camp and Retreat Center
Challenge Camp Application & Registration Form

Mail completed form to:
Duffield Camp Registrar
53 Lynbrook Ave.
Tonawanda, NY, 14150
Attn: Challenge Camp
716-440-9833

Camper Information:
Camper's Name: Last_____ First_____ Nickname _____
Camper's Address: _____ City _____ State ____ Zip _____
Camper's Phone_____ Age ____Sex____ Date of Birth ___/___/___

Primary Care Provider's Information:
Person filling in form: _____Relationship: _____ Phone: _____
Provider Name: _____Relationship: _____ Phone: _____
Provider Address: _____ City _____ State ____ Zip _____
Best way to contact: _____ Email address_____

Emergency Contact Information:
1st contact name: _____ Phone _____ Relationship_____
2nd contact name _____ Phone _____Relationship _____
3rd contact name _____ Phone _____Relationship _____
If the primary care provider plans to be away during the camp session, please indicate.
If so, the 2nd contact should be informed that he/she will be on 24 hour call.

Health Insurance Information:
Insurance Company: _____ Name of Policy Holder: _____
Policy Number: _____ Group Number: _____ Medicaid Number _____

Physician/Medical Information: WE WILL ONLY ACCEPT DUFFIELD CAMP PHYSICAL FORMS
Every camper must have a complete physical dated within one (1) year prior to the camp session. Please have your physician fill out **both** the physical and the over the counter medication form and **Sign and date** the forms.
Any medication changes after the physical exam must be accompanied by a current written Prescription from the camper's physician.
Name of Physician: _____
Physician's Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Date of physical: _____
Has camper been hospitalized within the past three (3) years? _____
If yes, please explain in detail with dates:_____
_____

Ambulatory Abilities:

Does not apply	___	Walks with assistance	___	Slow walking	___
Unsteady walking	___	Difficulty on stairs	___	Braces	___

Other:_____

Tee Shirt Size _____

Communication/Needs: ___Does not apply/ communicates well and is easily understood
___Does not apply ___Limited, but communicates needs ___Impaired speech
___Uses gestures/signs ___Uses communication board ___Responds to directions
Other:_____

Sleeping Needs/Information: ___Does not apply/Sleeps through the night
___Awakens during the night ___Walks in sleep ___Tends to wet the bed
Problems at bedtime (describe): _____

Toileting Issues/Information: ___Does not apply/ Takes care of toileting needs by self
___Needs reminders during the day ___Needs reminders during the night
___Diapers at night
___Other(describe): _____

Swimming Abilities: (Lifeguards are present at the pond when we swim.)
___ Enjoys water and can swim independently in deep water
___ Limited ability and should not go in the deep water ___Must wear a life jacket in the water
___ Other(describe): _____

Assisted Daily living Skills:

	Independent	Verbal Prompts	Partial Assistance	Full Assistance
Showering				
Brushing Teeth				
Hair Care				
Shaving				
Toileting				
Dressing				
Menstruation				

Allergy Information: ___Does not apply (no allergies)

Allergy to:	Reaction:	Treatment:
Dust/Mold		
Insect Bites:		
Animals:		
Latex		
Sunscreen		
Food:		
Food:		
Medications:		
Medication:		

Other:_____
(**Must bring epi pen, bee sting kit, lactose free milk if appropriate**.)

Food/Dietary Concerns:

Eating	Independent	Needs Help	Dependent	Eating	Independent	Needs Help	Dependent
Feeds self				Drinks			
Cuts food				Cleans self			
Pours drink				Other			

Food allergies (describe):_____
GERD or REFLUX (explain) _____
Diabetes / foods to avoid: _____
Lactose intolerant/ foods to avoid: _____
Needs to be reminded to chew food: _____
Tends to over eat and needs reminders: _____
Other: _____

Interests/Behavioral Issues:

What does the camper like to do in spare time? _____
Does the camper work? (explain) _____
What does the camper like? _____
What does the camper dislike? _____
What kinds of things upset/frustrate the camper? _____
What strategies are used to manage behavior?_____
Circle any of the behaviors that apply:

Excitable	Passive	Friendly	Cooperative	Stubborn	Quiet
Active	Sensitive	Aggressive	Tantrums	Helpful	PICA
Inquisitive	Depressed	Sociable	Self-injurious	Bites	Hits
Non-compliant	Wanders	Runs away			

Uses inappropriate language inappropriate sexual behaviors
Please explain any circled items and describe strategies used to manage behaviors.

_____
Does camper smoke? _____ How often? _____(**There is no smoking allowed at camp**)
Should camper avoid exertion due health concerns? _____
Is camper's interaction with children appropriate? (If not, explain). _____
Other important information: _____

_____

Symptoms:(Circle any that apply frequently and how they are treated.)

Nausea		Nightmares	
Diarrhea		Dizziness	
Constipation		Earaches	
Stomach aches		Headaches	
Over fatigue		Specific Behaviors	

Present Medications: List all medications presently being used. Medications must accompany the camper. Medications must be in a prescription bottle and match this list as well as the doctor's list. If medication changes by the time of the camp session, a written prescription from the doctor must accompany the camper.

Medication	Dosage	Times Given	Reason

Permission Page*: (This must be signed for camper to attend camp.)*

The camper has my permission to attend Camp Duffield.
I have completed the preceding forms completely and to the best of my knowledge.
I attest to the fact that the camper is free of all communicable diseases prior to attending camp.
I give permission for camper's picture to be used in camp promotional materials.
I give permission for camper's picture to be taken and distributed to campers, staff and website.
I agree to send the following:

$100.00 non-refundable deposit with this application by May 1st.
$420.00 balance DUE no later than June 1st. (must be paid in full)

The full amount may be sent at any time prior to June 1st. If the camper has to cancel due to health issues prior to the camp session, the balance of $420 will be returned. If the camper is sent home during the camp session due to behavioral problems, there will be no refunds.

Signature: _____ Date: _____
Print name: _____ Relationship to Camper: _____

Medical Permission: ***(This must be signed for camper to attend camp.)***

Please be prepared to fill out a form when registering camper on the first day of camp session indicating any illnesses, injuries, hospital visits, and medication changes that may have occurred after sending in this form. Changes must be accompanied by physician's note indicating that camper is able to participate in camp activity. This means transport person is qualified to fill out paper work. All medications due before 2pm must be given to camper before they are signed in.

The nurses at camp may give camper routine medications and over the counter medications, monitor health status, and provide first aid and routine care. If there is any change in the camper's care or medical status, The caregiver will be notified.

If emergency treatment is necessary, I give permission for camper to be brought to the nearest emergency room available by ambulance or staff car for treatment. I authorize staff to release all records necessary for insurance purposes so that the insurance company can be billed for the visit, lab tests, and/or x-rays if necessary.

The camper will bring all necessary medications and supplies needed for seven (7) days. However, if camper needs any additional prescription medication, the caregiver will be notified and arrangements will be made.

In consideration of admission of camper to Camp Duffield, the undersigned hereby releases any and all claims for injuries suffered or sustained by the camper in going to or coming from camp, or while at camp and consents to hospital or medical care if needed.

Signature _____
Print Name _____Date _____

Duffield Camp and Retreat Center
Physician's Report
Date of Camp: July: 3-9

Mail completed Form to:
Duffield Camp Registrar
53 Lynbrook Ave..
Tonawanda, NY 14150
Attn: Challenge Camp
716-440-9833
Due: June 1st

CAMPER'S NAME _____

PHYSICAL

To be completed by camper's Medical Doctor

This form may be mailed separately from camper's application, but **is due no later than June 1st.**

We will only accept this form for your campers physical. Do not wait for this form to mail in your application.

INCLUDE CURRENT MARS

PLEASE PRINT

PHYSICIAN'S NAME _____PHYSICIAN'S PHONE _____

PHYSICIAN'S ADDRESS _____

Your medical doctor must complete the next three (3) pages. The camper's exam must be dated within one (1) year from the camp session.

DIAGNOSIS	STATUS

ALLERGIES	REACTION/TREATMENT

IMMUNIZATION-most up to date	DATE/RESULT or attach sheet
HAEMOPHILUS INFLUENZA TYPE B	
DATE OF LAST TETANUS SHOT -must be current *********	
TB TEST DATE- and results	
MMR	
HEP B SERIES	
POLIO	
CHICKEN POX/VARICELLA	
PERTUSSIS- must be current **********	
MENINGOCOCCAL VACCINATION	

COVID VACCINATION (DATE) _____

Can this camper go swimming? _____ Restrictions _____

Does this camper have seizures? _____ Type _____ Last Episode _____ Restrictions _____

Other orders or recommendations (include skin care)

_____

_____

PHYSICIAN'S SIGNATURE _____Date_____

Duffield Camp and Retreat Center
Physician's Report

Mail completed Form to:
Duffield Camp Registrar
53 Lynbrook Ave..
Tonawanda, NY 14150
Attn: Challenge Camp
716-440-9833
Due: June 1st

CAMPER'S NAME _____

DATE OF EXAM ____/____/_____ **HT** _____ **WT** _____**P** _____ **BP** _____**RR** _____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEERT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			

MEDICATIONS

Please list all medications the camper is currently taking. Any medication changes after exam date must be accompanied by a current written prescription from camper's physician. **Reasons must be given for each medication.**

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

PHYSICIAN'S SIGNATURE _____ **DATE** _____
PRINTED NAME _____ **LICENSE NUMBER** _____
ADDRESS _____ **PHONE** _____
CITY _____ **STATE** _____ **ZIP** _____ **FAX** _____

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Physician' Report

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CAMPER'S NAME _____

OVER THE COUNTER MEDICATION FORM

Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benydryl (oral or topical) for swelling, hives, allergic reaction as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe) _____

PLEASE BE SPECIFIC IN ANY OF THE ABOVE ORDERS FOR YOUR PATIENT.
"ALL PAGES OF PHYSICAL FORM NEED DOCTORS SIGNATURE."

PHYSICIAN CONSENT

Physician Signature _____ Date _____

Printed Name _____ License Number _____

Address _____Phone _____

City _____ State _____ Zip _____ Fax _____

Authorization of for medical treatment persons over 18

Notary Public Signature Required

I, _____do hereby authorize Camp Duffield Staff to sign for any medical treatment deemed necessary for myself. My date of birth is _____.

This authorization is valid from _____(date) through and including _____(date).

Today's Date_____

Print Name_____

Signature _____

The person herein described has appeared before me and is known by me or has presented sufficient identification, to prove that he or she, is indeed, the above individual.

Date_____

Notary Public Signature/Stamp_____

Health Insurance Company_____

Identification Number _____Group No._____

Place of Employment_____

You Must Provide a photocopy of insurance card.

Camper Physician:_____Phone_____

Camper Dentist/Orthodontist:_____Phone_____