



Primary Contact Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Contact Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Contact Email: \_\_\_\_\_

Name of Secondary Contact: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Secondary Contact Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Contact Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Please provide the Names and Phone Numbers for an Emergency Contact(s) and/or Agency and/or Case Manager not listed above:**

## **INFORMATION FROM CAMP**

Contact: How would you as Parents/Guardians/Staff like to receive information from camp (acceptance or non-acceptance, pre-camp information, reports, etc.).

- I would like to receive paper copies in the mail.
- I would like to receive digital copies by email.
- I would like to receive paper and digital copies.

**HOME INFORMATION**

Applicant Lives:  Independently (with or without roommates; no staff or minimal staff)  
 Assisted Living (Staff present the majority of the time)  Group Home  
 Nursing Home  with Family  Other: \_\_\_\_\_

**Activities of Daily Living:**

Definitions:

Independent – Individual is able to complete the task with no assistance and little to no prompting.

Supervision – Individual is able to complete task with some prompting or reminders.

Minimal Assistance – Individual needs frequent prompting, step by step instructions, and/or some physical assistance to complete the task.

Moderate Assistance – Individual needs physical assistance to complete the task.

Total Assistance – due to physical limitations or skill deficits, the individual is unable to complete the task and it must be done for them.

Please indicate the individual’s level of independence in the home for each of the following areas.

	Independent	Supervision	Minimal Assistance	Moderate Assistance	Total Assistance
General Toileting					
Toileting after bowel movement					
Showering Body					
Washing Hair					
Combing/Brushing Hair					
Styling Hair (particularly if long)					
Dressing while dry					
Dressing while wet					
Brushing teeth					
Mobility					
Washing Hands					
Swimming					

Serving themselves food					
Pouring beverages					
Cutting food					
Feeding themselves					

Comments on the areas above or any additional information about this individual's independence level that would be helpful to caregivers:

What does this individual's sleep routine look like? (Do they sleep through the night? Do they take naps or rest during the day? What are their typical sleeping hours?)

How does this individual communicate?

- verbal       non-verbal       vocalizes       communication device       sign  
 eye gaze     responds to choices     gesture     leading someone to desired item/activity

Comments about this individual's communication:

**SOCIAL STUDY**

Please indicate this individual's level for each category as compared to typical individuals of comparable age.

	In the Home Environment			In Social Settings		
	Below Average	Average for Age	Above Average	Below Average	Average for Age	Above Average
Maturity						
Self Esteem						
Independence						
Necessary supervision						
Relating to others						

If you indicated that this individual was below average in any category, please describe.

Please list a few interests or hobbies of this individual.

Is this individual afraid of anything? Do they have nightmares? Please describe. Is there anything that comforts him or her?

Has this individual ever attended a summer camp before?  Yes  No

Has attended Elks Camp Grassick  Has attended \_\_\_\_\_

How do you feel that this individual would adjust to being away from home and in a camp environment?

How do you feel this individual will adjust to living with 5-8 cabinmates?

At camp, there is a very full schedule of activities. Do you believe this individual is able to keep an active pace for the entire camp session?

## **BEHAVIOR STUDY**

Please describe this individual's behavioral baseline. (Describe what they look and sound like when they are calm and content. How do they usually behave or interact with others when they are at their best?)

On a typical day, how much time is this individual at their behavioral baseline?

- Almost always, rarely dysregulated
- Majority of the day, occasional periods of dysregulation
- About half their day is regulated/baseline
- Rarely at baseline, frequently dysregulated

Please describe how this individual handles transitions between activities, environments, or routines. Are there specific strategies or supports that help them adjust to changes?

Does this individual exhibit any unexpected behaviors (discipline problems, periods of dysregulation or responsiveness to consequences) in his/her home environment? If yes, please explain.

Does this individual exhibit any unexpected behaviors (discipline problems, periods of dysregulation or responsiveness to consequences) in social settings? If yes, please explain

Does this individual have any repetitive behaviors, stims or tics? If yes, please describe. What do they look and sound like?

What is the frequency of repetitive behaviors, stims, or tics? Are they triggered by anything? Are they escalated by anything? Are they deescalated by anything?

Please check the behaviors that this individual exhibits when dysregulated. Note: Please be honest. These behaviors do not automatically disqualify an applicant and these questions help us to better serve our campers.

- Aggressive physical behaviors such as hitting, kicking, biting, pushing, etc.
- Screaming/yelling       Elopement       Self-Harm       Disrobing
- Lying/manipulation       Tactile Defensiveness or Sensory Dysregulation
- Frequent expressions of dissatisfaction and/or whining

**Elks Camp Grassick**  
**PO Box F, Dawson, ND 58428**

**701-327-4251**  
**campgrassick@gmail.com**

For each behavior that you selected in the last question, please describe: What triggers the behavior? What escalates the behavior? What deescalates the behavior? What does the behavior look and sound like? How frequently does the behavior occur? How long does the behavior typically last?

Are there any behavior plans or therapeutic practices that work with the individual that we should continue at camp? If a behavior plan is in place, please attach.

Considering the camp schedule, number of other campers, different environment, and amount of sensory input (activity, noise, changing weather, etc.), do you feel that this individual will be able to self-regulate?

Please attach any additional, pertinent information about this individual.

### MEDICAL FORM/HEALTH HISTORY FOR ELKS CAMP GRASSICK

To be completed by the parent/guardian or caregiver. This portion must be sent to Camp Grassick with the application. **Please note: A doctor's physical form is no longer required for camp.**

Name of Individual: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Medical Diagnosis: \_\_\_\_\_

Secondary Medical Diagnosis: \_\_\_\_\_

Individual's Primary Care Provider: \_\_\_\_\_

Clinic where Provider Works: \_\_\_\_\_ Phone#: \_\_\_\_\_

Individual's Insurance Company: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Medical Assistance # (If Applicable): \_\_\_\_\_

### EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any history of seizure disorder  Yes  No

If yes, list seizure type: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

Controlled by medication  Yes  No

### ALLERGIES & DIETARY RESTRICTIONS

(Check all that Apply)

No Known Allergies  Latex Allergies  Epi Pen Required

Allergies to Medications: \_\_\_\_\_

Allergies to Food: \_\_\_\_\_

Seasonal or Environmental Allergies: \_\_\_\_\_

Allergies to Insect Bites or Stings: \_\_\_\_\_

Does this individual have any special dietary needs? Is there anything this individual is not allowed to eat due to medical or religious reasons? Do they have restrictive eating habits? If so, what are their safe foods?

### **VACCINES**

Are all vaccines up to date?  Yes  No

Date of last Tetanus vaccine: \_\_\_\_\_

### **ASSISTIVE DEVICES**

Does the individual use assistive devices (check all that apply)?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Orthotics          | <input type="checkbox"/> Communication Device | <input type="checkbox"/> C-Pap Machine       |
| <input type="checkbox"/> Crutches or Walker | <input type="checkbox"/> Dentures             | <input type="checkbox"/> Glasses or Contacts |
| <input type="checkbox"/> G-Tube or J-Tube   | <input type="checkbox"/> Hearing Aids         | <input type="checkbox"/> Implanted Device    |
| <input type="checkbox"/> Inhaler            | <input type="checkbox"/> Wheelchair           | <input type="checkbox"/> Other: _____        |

Notes on assistive devices:

## MEDICATIONS

Please list medications this person will be taking while at Camp Grassick or attach a list:

Options for bringing meds to camp: (This will help to speed up the check-in process.)

1. Pre-packaged by a pharmacy (blister packs, pill packs, etc.). These should have name of individual, medication and dosage clearly labeled.
2. Packed at home in a med planner box with a list of medications, doses, times, and a description of medication. (ex. Loratadine, 10 mg, 1x daily in AM, small white oval imprinted with L612)

Liquid medications should be kept in original containers.

Medication:	Time(s):	Dosage:	Special Instructions: (i.e., crushed)
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Please check any medications this person may take if needed while at Camp Grassick:

Any OTC medications       Tylenol/Acetaminophen       Advil/Ibuprofen

Benadryl     Allergy medicine     Cough Drops       Cough/Cold medicine

Pepto Bismol       Aleve/Naproxen       Other \_\_\_\_\_

Is there any OTC medicine that this person should **NOT** take? \_\_\_\_\_

Please list any recent surgeries, infections, or serious illnesses:

## HEALTH HISTORY

Has the individual ever been diagnosed with or experienced any of the following conditions?

(Check all that apply)

- ADHD       Anxiety       Arthritis       Asthma       BPD
- Broken Bones       Bleeding/Clotting Disorders       Chicken Pox
- Concussions       Depression       Diabetes       Dislocated Joints
- Epilepsy/Seizure Disorder       Frequent Ear Infections       Hepatitis
- Frequent Headaches/Migraines       Frequent Sinus Infections
- Hearing Impairment       Heart Defect/Disease       Measles
- High Blood Pressure       Heat Illnesses       Mononucleosis
- Loss of consciousness/Fainting       Mumps       OCD       ODD
- Pneumonia       PTSD       Sleep Talking       Sleepwalking
- Spina Bifida       Stroke/TIA       Vision Impairment

Other: \_\_\_\_\_

Please elaborate on any of the checked boxes if necessary:

Any other specific concerns or pertinent information concerning this person's health that the staff of Elks Camp Grassick should be aware of?

## ELKS CAMP GRASSICK FEE AGREEMENT

**Please do NOT send payment until this individual has been accepted. Payment will be due at check-in unless other arrangements have been made.**

Camper's Name: \_\_\_\_\_

Name of party responsible for payment: \_\_\_\_\_

Parent/Guardian/Responsible Party: We ask that you pay what you can towards your camper's fee. We never turn down campers due to inability to pay and we will not ask for any proof of income. Simply pay what you feel comfortable paying, and the rest will be covered by scholarships. Paying any amount towards camp fees helps us continue to provide services for all campers. Camp fees may also be paid in payments. For more information about paying for camp, please visit the FAQ section of our website.

Please check which camp this individual is applying for:

Note: Fees will change if applicant is accepted to a session that is different from the session they initially applied to.

Therapy Camp - \$550

Skills Camp - \$425

Recreation Camp - \$175

Medical Respite Camp - \$250

Adult Camp - \$150

I hereby agree to pay \$\_\_\_\_\_ for this individual to attend Elks Camp Grassick.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you have any questions, please feel free to call camp at 701-327-4251.