CAMP BEAUSITE NW
SUMMER CAMP APPLICATION 2019

Before filling out this registration application, please read the “For Parents/Caregivers” and “Registration” tab on our web site carefully. In addition to this registration form, we will also need the following to sign up your camper: Signed Physician Medical History Form, Dietary form, medication list, photo release, $50 deposit, and (if applicable, only if you are financially eligible and are NOT getting DSHS/DDA benefits) Financial Aid Request Form. ALL ARE DUE BY JUNE 1, 2019
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Please select your PREFERRED session based on age of the camper as of June 1st.
_____ Session 1 (ages 30+) June 24-28
_____ Session 2 (ages 18-29) July 1-5
_____ Session 3 (ages 6-13) July 8-12
_____ Session 4 (ages 14-20) July 15-19
_____ Session 5 (ages 20+) July 22-26
_____ Session 6 (ages 18+) July 29-Aug 2

Please select an ALTERNATIVE session based on the age of camper as of June 1st. (in case we cannot accommodate your first choice)
_____ Session 1 (ages 30+) June 24-28
_____ Session 2 (ages 18-29) July 1-5
_____ Session 3 (ages 6-13) July 8-12
_____ Session 4 (ages 14-20) July 15-19
_____ Session 5 (ages 20+) July 22-26
_____ Session 6 (ages 18+) July 29-Aug 2

Camper’s Full Name: First: ______________________ Last: ____________________
Age: _________ Gender: M or F Birth Date: ____________________

Parent/Caregiver Information
Full Name: ____________________________________Phone_________________________
Address:____
Email: ____

Camper’s Disability: Primary: ____________________ Secondary______________________

Emergency Contacts (Other than above)
1. Name:____
Relationship: __________________________Phone: ____________________
2. Name: ____
Relationship: __________________________Phone: _____________________

Physician’s Name:
____Phone:__________________________

Name of Group Living Facility (if applicable) ________________________ Phone: __________
Address:____
Email:____

COUNTY of residence: ____
Custody Status: ____ Person/Agency
Responsible for Payment:
Name: First ________________________ Last ______________________________________
Phone: _____ ________________________Email: ___________________________________
(if different from parent/guardian)
Mailing address: (if different from parent/guardian)

If using DSHS/DDA or other agency funding, please instruct your case manager to send a letter or email programs@campbeausitenw.org, verifying your camper's benefits for summer camp. This vertification must be received from your Case Manager by June 1st.
Case Manager Name: ____
Office Location: _______________________________________Phone:__________________
Email: ______________________

Daily Living Information
Camper Name: ______________________________ Nickname:__________________________
Height: _______ Weight: ______ Date of last height and weight check: ____________________

HEARING: Does the camper have normal hearing? Yes No
Percentage of hearing loss:_______________

SPEECH: Does the camper use normal English Language? Yes [ ] No
Does the camper use an AAC Device?
If so, which one?____________________________________PEC Boards?__________ (If yes, please bring the boards and/or devices as we do not have a supply of devices on hand.)

DIETARY: Is the camper allergic to any foods:
If yes, make sure to fill out the "Dietary Form" completely. Is the camper on a special diet? [ ] Yes No If yes, please explain:
____
____
____

Is the camper tube-fed? [ ] Yes No Does the camper receive any hydration or nutrition by mouth, or do they rely exclusively on the feeding tube? If yes, please explain.
____
____
____
____

VISION: Does the camper have normal vision? [ ] Yes No
Wears glasses? [ ] Yes No If "No", please tell us the degree of loss:
____
____

MOBILITY: Does the camper use a device that helps with mobility? [ ] Yes No
If yes, please list the devices the camper uses (e.g. wheelchair, walker, other, etc.)____
____
____
*Note: Mobility device(s) must be brought to camp and in working condition.
TRANSFERS: Does the camper need transfer assistance? [ ] Yes No*
*No means that the camper can safely transfer to bed and vehicle independently, responding appropriately to verbal clues
If "Yes", what kind of assistance is needed? Explain: (indicate TOTAL assistance required with all activities of daily living)"____
____
____
____

Will the camper be bringing adaptive devices or equipment with him/her to camp?
If yes, check all that apply" [ ] C-PAP [ ] Braces [ ] Night
Braces [ ] Splint [ ] Retainer [ ] Prosthesis [ ] Glasses [ ] Hearing Aid [ ] Dentures [ ] Shunt [ ]
Car Seat/Booster Seat [ ] Helmet [ ] Other______________

TOILET: Is toileting an issue for the camper? [ ] Yes No
Diapers/Briefs? [ ] Yes [ ] No [ ] At Night Only Catheter: [ ] Yes [ ] No
If yes, is it indwelling or intermittent? (Circle) Colostomy: [ ] Yes [ ] No If yes, please elaborate:
____
____
____ ____
____ ____
DRESSING: Does the camper need any assistance with bathing and dressing? [ ] Yes x No If yes what assistance is needed?
____
____
SLEEPING: Does the camper have difficulty sleeping away from home? [ ] Yes x No
If "Yes", please explain sleep issues and what supports/assistance are needed (note – campers sleep in brand new heated group bunkhouses in individual raised beds, no railings):
____
____
____

Does the camper tend to wander or run away? [ ] Yes No
If yes, please describe tips or techniques for keeping him/her with group____
____

Please complete on-line, or print and mail BY JUNE 1, 2019 (with required medical, dietary, photo release, and signed physician forms) to:

Camp Beausite NW
Director of Programs
PO Box 1227
Port Hadlock, WA 98339
Questions? Contact Cheryl Smith, Director of Programs, 360-808-5629 or 360-732-7222