



# 2010 GEAR-UP APPLICATION

August 7 – August 13, 2010 at  
EASTER SEALS CAMP WOODDEDEN

### FOR OFFICE USE ONLY

Date rec'd: \_\_\_\_\_  
Approved: \_\_\_\_\_

ID#: \_\_\_\_\_  
Confirmation Sent: \_\_\_\_\_

### IMPORTANT REMINDERS

- Applications will be processed by the date that the completed application form with the accompanying fee payment is received in the Easter Seals Ontario Recreation Office.
- Acceptance into this program is dependent upon meeting the eligibility criteria and available space.
- Send completed applications to *Recreation Co-ordinator, Easter Seals Ontario, One Concorde Gate, Suite 700, Toronto, ON, M3C 3N6*. If you have any questions or concerns please call 416-421-8377 x 325 or 1-800-668-6252 x.325 or e-mail: [camp@easterseals.org](mailto:camp@easterseals.org)
- **PLEASE NOTE:** Transportation to and from camp is the responsibility of the participant.

### PARTICIPANT PROFILE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Disability/Diagnosis: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

Date of Birth: (dd/mm/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ kgs.

Cabin mate request: \_\_\_\_\_

Are there any activities you must avoid? (Please specify) \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

**Primary Contact:**     Dr.     Mr.     Mrs.     Ms.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Secondary Contact:**     Dr.     Mr.     Mrs.     Ms.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

**MEDICAL BACKGROUND**

Number of medical visits within the last 6 months: \_\_\_\_\_

Reason: \_\_\_\_\_

**Allergies?**

no  yes Use an: Epi-Pen/Twinjet?  no  yes

Please list all allergies (*food, medication, environmental*):

**Asthma?**

no  yes Use a nebulizer (air compressor)?  yes  no

Please describe: \_\_\_\_\_

**Seizure Disorder/Epilepsy?**

no  yes Type: \_\_\_\_\_

Frequency: \_\_\_\_\_

Triggers: \_\_\_\_\_

**Shunt?**

no  yes Type: \_\_\_\_\_

Location: \_\_\_\_\_

**Is your child prone to respiratory infections?**

no  yes

Please Describe:

**Has your child had pneumonia more than once in the last two years?**

no  yes Dates: \_\_\_\_\_

**Does your child require suctioning?**

no  yes How often? \_\_\_\_\_

**Does your child use a BiPap machine at night?**

no  yes When? \_\_\_\_\_

**Does your child require oxygen?**

no  yes When? \_\_\_\_\_

*(It is the parent's/guardian's responsibility to arrange the supply of oxygen to camp prior to the start of camp)*

Flow Rate: \_\_\_\_\_

**\*Does your child require a ventilator machine?**

no  yes When? \_\_\_\_\_

**\*Does your child have a tracheostomy?**

no  yes

**\* If your child has a tracheostomy or uses a ventilator, you will need to send a PCA familiar with their care to camp**

**ACTIVITIES OF DAILY LIVING:** *Please check the appropriate section*

Assistance Required	Minimal Assistance	Moderate Assistance	Total Assistance	Describe
Dressing – Upper body				
Dressing – Lower body				
Eating				
Toileting				
Brushing teeth				
Washing hands/face				
Showering/bathing				
Transferring on/off toilet				
Transferring in/out of bathtub/shower				
Transferring in/out of bed				
Transferring in/out of wheelchair (if applicable)				

If your child requires assistance with transferring please indicate her/his preferred method:

Hoyer lift (please bring your own slings)  2 person lift  Pivot Transfer

### SLEEPING AT CAMP

Bedrails required?:  yes  no  
Do you require turning during the night?  yes  no  
How often? \_\_\_\_\_  
Sleeping difficulties?  yes  no  
Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### BLADDER & BOWEL ROUTINES

Are you independent in toileting?  yes  no  
  
Do you have bladder control?  
During the day?  yes  no  
During the night?  yes  no  
  
Do you have bowel control?  
During the day?  yes  no  
During the night?  yes  no  
  
Do you require:  
 diapers/attends       catheters  
 Mitrofanoff       bladder  
irrigation/instillation  
 disempactions       suppositories  
 enemas (please circle type)      cecostomy      fleet  
 colostomy       Ileoconduit  
 condom drainage  
 Other \_\_\_\_\_  
  
Please describe any assistance required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DIET & EATING HABITS

Diet:  Regular  Vegetarian  Soft  
 Cut into bite size pieces  Pureed  Other  
  
Please describe: \_\_\_\_\_  
  
Eating Habits:  Hearty  Average  Fussy  
How long does it take you to eat? \_\_\_\_\_  
  
Do you have any difficulties:  
  
 Swallowing?  Chewing?  Drinking?  No  
  
Do you have a:  G-tube  J-tube  
  
If **YES**, please complete the following:  
How long does the feed take to run? \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
  
Do you eat anything by mouth?  yes  no  
What? \_\_\_\_\_  
  
Have you had a Fundoplication?  yes  no  
  
Further eating instructions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please keep in mind that camp is not staffed with Registered Dieticians or Nutritionists trained to implement specialized diets. We will do our best to accommodate common diets, such as vegan, high fibre and low caloric diets. You can bring food from home to supplement the camp food. Easter Seals camps offer a Nut Aware environment. We ask that you not to bring any nut or peanut products to camp.**

## COMMUNICATION

Are you clearly able to express your care needs to the staff?  yes  no

How do you communicate?  Words  Augmentative Communication, type: \_\_\_\_\_

Please describe your ability to communicate: \_\_\_\_\_

Are you able to direct your own care?  yes  no (Participants should be familiar with their care requirements.)

Are you able to participate in-group discussions?  yes  no

Do you wear:  Glasses  Contact Lenses  Hearing Aids

## Additional Information:

**Please check (✓) all equipment that you will be bringing to camp:**

Electric wheelchair  Manual wheelchair – requires pushing  yes  no  Walker  Feeding Pump

Other \_\_\_\_\_

**Any additional information to help us care for you?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Easter Seals Ontario operates with the generous donations of corporate partners, service clubs and individuals. Fundraising is important for Easter Seals Ontario to continue to offer recreational programmes. We ask for your support.**

1. I agree to the use of photos or videos of my child/myself to promote Easter Seals Ontario, Easter Seals Canada, and/or Easter Seals' provincial member associations?  Yes  No
2. May we share photos or videos of your child/yourself among campers and staff?  Yes  No
3. I agree to have my name and address shared with the Easter Seals Fundraising Department:  Yes  No

## Consent

I acknowledge that, to the best of my knowledge, the information on this application form is correct. I understand that this is an application for camp and does not guarantee confirmation. Notification of confirmation will be sent by mail at a later date. To meet your needs and have the ability to care for you we must collect personal information about you and distribute this information to people who will care for you. Easter Seals Ontario complies with the Personal Health Information Protection Act (PHIPA). All the information gathered is stored in a confidential and safe manner.

**Participant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_