



APPLICATION FOR 2018

Check the camp location for which you are applying:

- Camp Dragonfly at Swatara (June 1, 2 & 3)
OR
 Camp Dragonfly at Hebron (June 8, 9 & 10)

How did you learn about Camp Dragonfly?

- Newspaper Church Bulletin Hospice Brochure Radio/TV Counselor Hospice Staff Member
 Hospice of Central PA Website Social Media
 Other (please specify): _____

Directions:

Please complete the following application by answering all questions as completely as possible. The more information you can provide, the better we can determine how to make your camper's weekend the best possible experience for him/her.

The child's parent or legal guardian must complete this application and provide all signatures.

If you need assistance in completing this application, please call Hospice of Central Pennsylvania.

Please return the completed application as soon as possible as campers are accepted on a first come, first served basis. **All application materials must be received prior to camper interviews being scheduled.**

Hospice of Central Pennsylvania
1320 Linglestown Rd
Harrisburg, PA 17110

Main office: 717-732-1000

Pottsville Area: 570-628-2290

Toll free: 1-866-779-7374

Child's Name: _____

Declaration:

The information on this application is accurate and correct to the best of my knowledge. I understand that if changes occur regarding the information supplied on this application, it is the responsibility of the individual completing this application to contact Hospice of Central Pennsylvania regarding the change(s).

Signature of Individual Completing Application

Date

Print Name: _____

Relationship to child: _____

Please include as many details as possible when answering the following questions. Attach extra pages if necessary.

1. Name of person who died _____

2. How was your child related to the deceased? _____

3. Describe the relationship that existed between your child and the deceased. _____

4. Date of the death _____ 5. Cause of death _____

6. Child's age at the time of the death _____ 7. Age of the deceased at time of death _____

8. Was your child present at the time of death? Yes No

If yes, how did the child deal with the death and how was he or she supported?

If no, how did your child learn of the death and how did the family, including your child, respond at that time?

9. What is your child's understanding of the death?

10. Did your child attend the funeral or memorial service? Yes No

If yes, describe their reaction.

11. What changes (if any) did you notice in your child's behavior or personality at the time of the death and during the weeks and months following the death?

12. Please describe how you feel your child is grieving at this time.

CAMPER'S NAME: _____

13. Does your child currently exhibit any of the following behaviors?

- | | |
|--|---|
| <input type="checkbox"/> Afraid to go to sleep | <input type="checkbox"/> Anger toward parent/guardian |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Clinging to parent/guardian |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Difficulty with schoolwork |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Cruelty to animals |
| <input type="checkbox"/> Destructive behavior | <input type="checkbox"/> Using drugs/alcohol |
| <input type="checkbox"/> Feels isolated at home/school | <input type="checkbox"/> Refuses to talk about death |
| <input type="checkbox"/> Other: _____ | |

Please explain all items checked above: _____

14. Has your child ever received support from a professional counselor (for example, a psychologist, psychiatrist, pastoral counselor, or school counselor)? Yes No

If yes, provide the name, address and phone number for each counselor.

May we contact the counselor(s)? Yes No

15. Has your child experienced the death of more than one person they loved? Yes No
Has your child had to change schools? Yes No

If yes to either question, please explain, with dates if possible.

16. Have there been any other changes or stressful situations in your child's life such as divorce, illness, a move, other losses, etc. within the year before or since the death? Please describe.

17. Does your child have any problems getting along with friends/peers, family members or authority figures such as teacher, counselors, coaches, etc.?

Yes No **If yes, please explain.**

18. What are your child's expectations for Camp Dragonfly?

19. What are your expectations for Camp Dragonfly?

CAMPER'S NAME: _____

20. Please tell us something about your child which makes you especially proud:

21. Please provide any additional information you feel necessary:

| | |
|--|-------------|
| <hr/> | |
| Signature of Parent/Guardian | Date |
| <hr/> | |
| Printed Name of Parent/Guardian | |

CAMPER'S NAME: _____



“GETTING TO KNOW YOU”
(To be filled out by the prospective camper, if possible)

Camper's Name _____

Camper will be given TWO Camp Dragonfly t-shirts at camp.

The camper's T-shirt size: Child: S M L

Adult S M L XL

So that we can try to make sure the weekend includes activities that you enjoy, please answer the following questions.

Please check all activities in which you enjoy.

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> swimming | <input type="checkbox"/> volleyball | <input type="checkbox"/> boating |
| <input type="checkbox"/> nature walks/hiking | <input type="checkbox"/> arts/crafts | <input type="checkbox"/> creative writing |
| <input type="checkbox"/> basketball/sports | <input type="checkbox"/> music | <input type="checkbox"/> fishing |

Do you know how to swim? Yes No

What other activities do you enjoy?

Have you ever spent the night away from home? Yes No

Have you ever been camping? Yes No

Are there any foods you can't eat? Yes No

If Yes, which foods:

What else would you like us to know about you?

CAMPER'S NAME: _____



CAMPER HEALTH HISTORY FORM

(To be completed by parent or guardian)

Please Print:

Camper's Name: _____
First Middle Last

Birth date _____ Age _____ Gender: Male Female

Child's Current Height _____ Child's Current Weight _____

Address _____

City _____ State _____ Zip Code _____

Mother's/Guardian's Name: _____

Relationship to Child/Camper: _____ Cell Phone () _____

Daytime Phone () _____ Evening Phone () _____

Address: _____

Email Address: _____

Father's/Guardian's Name: _____

Relationship to Child/Camper: _____ Cell Phone () _____

Daytime Phone () _____ Evening Phone () _____

Address: _____

Email Address: _____

Immunizations History:

(Please complete information below **or** provide a copy of your child's most current immunization record. If you need help with the following information, contacting your child's doctor's office will be helpful in obtaining this information)

| Immunizations | Year Primary Series Completed | Year of Last Booster |
|----------------------|--------------------------------------|-----------------------------|
| DPT | | |
| Measles | | |
| Mumps | | |
| Oral Polio | | |
| Rubella | | |
| Tetanus Shot | | |

Tuberculin Test: Type _____ Year last given _____ Result _____

Allergies

No known allergies

Does your child have allergic reactions to:

Medicines? Yes No

| Name of medicine | What happens? (rash, eye watering, swelling, breathing problems, etc) |
|-------------------------|--|
| | |
| | |

Food? Yes No

| Food | What happens? |
|-------------|----------------------|
| | |
| | |

CAMPER'S NAME: _____

Insect bites? Yes No

| Insect | What happens? | How do you treat? |
|--------|---------------|-------------------|
| | | |
| | | |

Medical supplies such as tape, band-aids, latex? Yes No

| Medical Supply | What happens? | How do you treat? |
|----------------|---------------|-------------------|
| | | |
| | | |

Other allergies? Yes No If yes, please specify

| Cause of allergy | What happens? | How do you treat? |
|------------------|---------------|-------------------|
| | | |
| | | |

Health History:

Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinence (toileting problems) | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Special Dietary Need |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Wears Contacts |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | |

With regard to those conditions you have checked above, please **add any information** that the camp staff or the adult in charge of your child should know. Also, list any activities in which your child should **not** participate.

CAMPER'S NAME: _____

Date of child's last physical examination _____

Were any medical or emotional problems noted at that time? Yes No **If Yes, Explain.**

Is your child currently under a physician's care for a medical or emotional problem? Yes No

If Yes, explain:

Has your child recently had a serious illness or injury requiring medical attention? Yes No

1) An illness lasting longer than a week? (Explain)

2) An operation or fracture? (Explain)

Is your child on a physician-prescribed medication that is taken on a regular basis? Yes No

If Yes, Explain.

Is your child restricted from participating in any physical activity? Yes No

If yes, specify activity.

Is there any other health reason(s), other than the information provided by you on this form, why your child **should not** participate in any of the Camp Dragonfly activities? **If so, please explain.**

Please provide any additional health or medical information you feel necessary:

CAMPER'S NAME: _____

Please note: It is very important that your child take all medications prescribed by his/her physician during Camp Dragonfly. Camp is NOT the time to give your child a break from taking his/her medications.

If your child takes medications for school attendance they need to take them at Camp so they can participate in activities and have a positive Camp experience.

If your child arrives at Camp without their medications you will be asked to go home and return with the medications before your child will be signed into camp.

Dietary Information:

Does your child have any problems with eating? Yes No

If Yes, please explain.

Please list any dietary needs:

Is your child a vegetarian? Yes No

Please provide any additional health information you feel necessary/important for us to be aware of:

CAMPER'S NAME: _____

Emergency Contact Information:

In case of emergency DURING CAMP and parent/guardian cannot be reached, contact:

1. Print Name _____ Relationship to Camper _____

Daytime Phone () _____ Evening Phone () _____

2. Print Name _____ Relationship to Camper _____

Daytime Phone () _____ Evening Phone () _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my child's participation in a Camp Dragonfly activity, I consent to:

- 1) the administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below, the Camp Dragonfly physician, the Camp Dragonfly nurse or the Camp Dragonfly director, and
- 2) the immediate administration of life-sustaining measures deemed necessary under the circumstances.

| | |
|-------------------------------------|-------------|
| _____ | |
| Signature of Parent/Guardian | Date |

Medical Insurance Information:

Company _____

Policy Number _____ Policyholder's Name _____

Preferred Physician/Medical Facility _____

Physician's Phone Number : Daytime () _____ Evening () _____

CAMPER'S NAME: _____

PHYSICIAN'S MEDICATION ORDER FORM

****FOR ADDITIONAL MEDICATIONS NOT INCLUDED IN ORIGINAL APPLICATION****

If your child is taking prescription medication, please send this form to your doctor to complete. Have your doctor return the form to you so that you can sign the authorization at the bottom of the page, and then return to us.

If your child is **NOT** taking any prescription medications, please check here and initial _____.

Please note: The first dose of a new medication must be administered at home.

CAMPER'S NAME: _____
First Middle Last

PLEASE PRINT:

The following medications must be given during camp:

| MEDICATION | DOSAGE | ROUTE | TIME(S) TO BE GIVEN |
|------------|--------|-------|---------------------|
| 1. _____ | | | |
| 2. _____ | | | |
| 3. _____ | | | |

Administration considerations (to be taken with water, food, milk, etc.?) _____

List any reasons for not giving medication at the prescribed time (for example- vomiting, fever, drowsiness, convulsions):

MUST BE SIGNED BY PHYSICIAN

Physician's Signature _____ Date _____
 Print name _____

PARENT/GUARDIAN AUTHORIZATION

I/We authorize and request Camp Dragonfly personnel to administer the medication(s) prescribed by our physician, and in so doing, release Camp Dragonfly, its agents, employees or representatives of any liability for any adverse or ill effects which may result from the administration of said prescribed medication.

Signature of Parent/Guardian _____ Date _____
 Print Name _____



OVER THE COUNTER MEDICATION PERMISSION FORM (Signed by Parent/Guardian)

**Please Print:
Child's Name** _____

First

Middle

Last

Medication dosage will be given according to age/weight guidelines.

The Camp Dragonfly nurse has permission to administer to the child listed above the following over the counter medications:

(Please Check)

all of the listed medications are acceptable

| | Generic medicine (form) | Purpose | Brand example |
|--------------------------|---|--|----------------------|
| <input type="checkbox"/> | Ibuprofen (pills) | Pain relief | Advil, Motrin |
| <input type="checkbox"/> | Acetaminophen (pills or chewable) | Pain relief; fever | Tylenol |
| <input type="checkbox"/> | Diphenhydramine Hydrochloride (pills or liquid) | Itching/hay fever | Benadryl |
| <input type="checkbox"/> | Diphenhydramine Hydrochloride (cream) | Skin irritation | Benadryl |
| <input type="checkbox"/> | Calamine and zinc oxide (lotion) | Skin protectant/ poison ivy | Calamine lotion |
| <input type="checkbox"/> | Bismuth subsalicylate/aspirin-like (liquid) | Upset stomach | Pepto bismol |
| <input type="checkbox"/> | Calcium carbonate chewable (pills) | Upset stomach | Tums |
| <input type="checkbox"/> | Loperamide hydrochloride (pills) | Diarrhea | Imodium |
| <input type="checkbox"/> | PolymyxinB, bacitracin, neomycin (ointment) | Prevention of infection cuts or abrasion | Triple antibiotic |
| <input type="checkbox"/> | Povidone-Iodine (ointment) | Prevention of infection for cuts or abrasion | Betadine |
| <input type="checkbox"/> | Deet (spray) | Insect repellent | Cutter; OFF |
| <input type="checkbox"/> | Benzocaine (spray) | Antiseptic, pain, itch | Solarcaine |
| <input type="checkbox"/> | Dextromethorphan, phenylephrine, chlorpheniramine (liquid) | Cough, decongestant, runny nose | Robitussin |

Signature of Parent/Guardian _____ **Date** _____

Print Name _____

Packing List for Camper

Basic Gear

sleeping bag (or sheets and a blanket)
pillow and pillow case
flashlight with good batteries
water bottle

Clothing

pair of sneakers
extra pair of sneakers or sturdy/comfortable walking shoes
jacket or sweater
sweatshirt
2 shirts--at least one long-sleeved
2 pairs pants/jeans (or shorts if weather is warm)
3-4 pairs of socks
3-4 changes of underwear
1 pair of pajamas or sweat suit
1 swimsuit and towel- **note: two piece bathing suits/bikinis are not permitted**
rain gear

Note: each camper will be provided with two Camp Dragonfly t-shirts at camp

Toiletries

toothbrush and toothpaste
deodorant
soap in plastic container or bag
bath towel
washcloth
comb and/or brush

Optional Items

sunscreen
insect repellent
hiking shoes
fishing gear (if your child will be fishing while at camp)

REMEMBER.....

If siblings are attending camp together, please make certain each child has his or her own toiletry items since they may be assigned to different cabins.

Since Camp Dragonfly cannot be responsible for lost or missing items, the staff strongly recommends that valuables such as radios, video games or jewelry be left at home. Also, since all meals, snacks and activities are being provided free of charge, **there is no need for your child or children to have money with them. Please leave all cell phones at home.**

The staff also recommends leaving items like perfume, hairspray, mousse, gum and candy at home, since these items tend to attract insects like ants, bees and wasps.