



# Camper Information Form

*This information is for use by Camp CILCA's staff in providing the highest quality experience possible for your camper. All of the information is considered confidential and is utilized in the strictest professional manner. All questions are optional.*

Camp: HandiCamp 1 - 2

Dates:

Name \_\_\_\_\_

Workplace &/or School \_\_\_\_\_

Hobbies & special interests \_\_\_\_\_

What activities is this camper especially interested in doing?  \_\_\_\_\_

arts & crafts  canoeing  swimming  hiking  \_\_\_\_\_

Any fears this camper has \_\_\_\_\_

Has this camper had any previous negative experiences at this or another camp?

Has this camper been away overnight before?  Yes  No

Does the camper require sign language interpretation?  No  Yes

Ratio of staff-to-camper care needed (circle one):    1:1    1:2    1:3    Campers

Please provide us with any additional information you think will help us in providing a positive experience for the camper. This might include:

\* Any special communication cues for needing to use the restroom or for feeling ill?

\* Any special habits \_\_\_\_\_

\* Any special routines (morning, evening, etc) \_\_\_\_\_

\* bed wetting or sleep walking concerns \_\_\_\_\_

\* ADHD \_\_\_\_\_

\* home environment / structure \_\_\_\_\_

\* dealing with behavior \_\_\_\_\_

\* recent events in the camper's life \_\_\_\_\_

\* Other helpful information (health, etc) \_\_\_\_\_

This form was filled out by: \_\_\_\_\_ Date \_\_\_\_\_

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

**PLEASE SUBMIT THIS FORM TO CAMP CILCA PRIOR TO ARRIVAL IF POSSIBLE.**

**Camp CILCA – 4124 Camp CILCA Road – Cantrall, IL 62625**

**Phone: 217-487-7497    Fax: 217-487-7497**

# HEALTH AND INFORMATION FORM HANDICAMP WEEK - CAMP CILCA

**NAME OF CAMPER**

**CAMPERS PHYSICIAN**

**PHONE NO.**

**PLEASE LIST CAMPERS PRIMARY DISABILITY / HEALTH CONDITION AND ANY OPERATIONS OR SERIOUS ILLNESSES IN THE PAST YEAR OR SO:**

**HOW WOULD YOU DESCRIBE THE CAMPERS CURRENT HEALTH?                      GOOD                      FAIR                      POOR**

**DATE OF LAST TETANUS SHOT:**

**LIST ANY CHRONIC HEALTH PROBLEMS (ASTHMA, HAYFEVER ETC.) AND TREATMENT WHICH THE NURSE SHOULD BE AWARE:**

**HAS THE CAMPER RECENTLY BEEN EXPOSED TO OR IS HE/SHE A CARRIER OF A CONTAGIOUS DISEASE?    YES    NO  
IF YES PLEASE DESCRIBE:**

**HAS THE CAMPER BEEN HOSPITALIZED OR TREATED IN THE EMERGENCY ROOM WITH THE PAST 3-4 MONTHS:    YES    NO  
IF YES PLEASE DESCRIBE:**

**LIST ANY ALLERGIES THE CAMPER MIGHT HAVE (include food allergies, medicine, plant, animal, insect)**

**LIST ANY DIETARY RESTRICTIONS THE CAMPER MIGHT HAVE?  
(diabetic, please list total number of calories per day)**

**DOES THE CAMPER HAVE SEIZURES? \_\_\_\_\_ IF YES, CURRENT STATUS (active controlled, etc.)**

**TYPE OF SEIZURE    FREQUENCY    DURATION**

**DATE OF LAST SEIZURE**

**DESCRIBE REACTION BEFORE, DURING AND AFTER SEIZURE**

**MEDICATIONS TO BE TAKEN WHILE AT CAMP:**

MEDICATIONS	DOSEAGE	TIMES GIVEN	REASONS FOR MEDICATIONS

**This health history and information form is correct so far as I know.**

**SIGNATURE OF PERSON PROVIDING THIS INFORMATION \_\_\_\_\_ DATE \_\_\_\_\_**

**RELATIONSHIP TO CAMPER \_\_\_\_\_**

**PLEASE SUBMIT THIS FORM TO CAMP CILCA PRIOR TO ARRIVAL IF POSSIBLE.**

**Camp CILCA – 4124 Camp CILCA Road – Cantrall, IL 62625    Phone: 217-487-7497    Fax: 217-487-7890**