Maritime Conference of the Seventh-day Adventist Church Inc.
Camp Pugwash 2018
2171 Gulf Shore Road   Pugwash NS B0K 1L0   902.243.2097

2018 CAMP PUGWASH BLIND CAMP
APPLICATION INSTRUCTIONS

MAIL $50 NON-REFUNDABLE APPLICATION FEE (money orders or cheques made payable to Maritime Conference of SDA) and COMPLETED APPLICATION FORM TO:

Camp Pugwash - Blind Camp
121 Salisbury Rd, Moncton NB E1E 1A6

CAMP DATES: JUNE 24 – JUNE 29, 2018

APPLICATION FORM AND FEE SHOULD BE RECEIVED BY JUNE 4, 2018.

Please use ink and print clearly.

1. **ALL INFORMATION is essential. Please fill in every blank.**
2. **MEDICAL INFORMATION MUST BE COMPLETED.**
   - First Time Camper - must visit your physician and have the form filled out and signed.
   - Returning Camper with ongoing or recent medical care - must visit your physician and have the form filled out and signed.
   - Returning Camper without ongoing or recent medical care - no visit is necessary but please neatly PRINT PHYSICIAN'S INFORMATION.
   - Ophthalmologist's Name & Number MUST be filled in, if applicable.
   - When applicable, additional Medical Insurance Name and Policy Numbers must be filled in, especially for prescriptions.
   - Any additional instructions for the camp first aid attendant must be received in writing and all prescriptions updated.
   - All medications MUST be in original containers.
   - All campers with bee/insect sting allergies, must come to camp with a filled prescription for antidote medication.
3. **Notification information for children 18 years or younger must be a parent or legal guardian.**
4. **CONSENT AND RELEASE section must be signed by a parent, legal**

guardian or the adult camper (18 years or older). Some activities may require additional signed waivers.

CAMP PUGWASH BLIND CAMP APPLICATION

JUNE 24 - JUNE 29, 2018

Office Use Only
Date Rec'd ________________
Fee Rec'd ________________

APPLICATION TO BE COMPLETED AND RETURNED FOR EACH CAMPER, INCLUDING PERSONAL SERVICE WORKERS.

INCOMPLETE APPLICATIONS WILL BE RETURNED.

Legally blind and visually impaired: Central visual acuity for distance is no greater than 20/200 in the better eye with correction.

Attended camp before at Camp Pugwash ____Yes ____No

Camper's name ____
Last First Initial

Mailing Address ____

____

City Province Postal Code

Phone (______) ______________________________

Male ____ Female ____

Height _______________ Weight ________________ Age _________

Birth date ____ (M/D/Y)

T-shirt size

Adult S___ M___ L___ XL___ XXL___ XXXL___ XXXXL___

Child 6/8___ 10/12___ 14/16___

Extent of Blindness	Details
____ Totally	____ Guide dog
____ Legally	____ Cane travel
____ Sighted Guide	____ Glasses

Contact lens(es) ____ No ____ Yes ____ right ____ left

Artificial eye(s) ____ No ____ Yes ____ right ____ left

Care of contact lens(es)/artificial eye(s)

Camper cared for independently ____ No ____ Yes

First aid attendant to take care of ____ No ____ Yes

If first aid attendant cared for, please give details of removal, care, reinsertions, solutions, & frequency, etc:______________________________

____

____

__

CNIB # ____

Provincial Health Care # (must be filled in) __________________________

Medical Insurance Name ____

_

Policy/Group/ID/Rx Number's _____________________________________

_

In case of accident or illness, notify:

Name ____

Relationship to camper ______________________________________

Home Phone # (____) __________________ Work # (____) __________________

Cell # (____) __________________ Email ______________________________

Address ____

_

Vac. Address ____

_

Vac. Phone # (   ) ________________________

HEALTH HISTORY

If yes, please explain.

Infections/disease(s) ____No ____Yes ________________________________

_

Asthma ____ No ____ Yes ________________________________

_

Thyroid disease ____ No ____ Yes ________________________________

_

Eating Disorder ____ No ____ Yes ________________________________

_

Diabetes ____ No ____ Yes ____ insulin ____ pill ____ diet

Epilepsy ____ No ____ Yes ____ grand mal ____ petite mal

Date of last seizure ________________________________

Ear infections ____ No ____ Yes ________________________________

Previous surgeries ____ No ____ Yes ________________________________

_

Sinusitis ____ No ____ Yes ________________________________

_

Kidney disease ____ No ____ Yes ________________________________

_

Heart disease/murmur ____ No ____ Yes ________________________________

Frequent cold/sore throat ____ No ____ Yes ________________________________

Other: ________________________________

MEDICATIONS taken at home (include name, dose and time taken - print)

____

_

____

_

MEDICATIONS: **Camper cared for and administered ___ No ___ Yes**

First aid attendant cared for and administered ___ No ___ Yes

INITIALS: ____________________ (PARENT/GUARDIAN)

ALLERGIES/ALLERGIC REACTIONS

a) Bee/Insect stings ___No ___Yes

Reaction ___ Severe ___ Moderate ___ Mild

Antidote ___ Benadryl ___ Anakit ___ Epikit

Other: ____

Camper cared for and administered ___ No ___ Yes

First aid attendant cared for and administered ___ No ___ Yes

b) Penicillin ___ No ___ Yes

c) Other Medication ___ No ___ Yes

d) Food ___ No ___ Yes

e) Environmental ___ No ___ Yes

f) Anaesthetic ___ No ___ Yes

g) Other ____

DATE of last tetanus/polio immunization booster ____________________

DIETARY RESTRICTIONS - Please list: ________________________________

____

____

LIMITATIONS/RESTRICTIONS OF ACTIVITIES AT CAMP

____ No restrictions

____ Archery ____ Belly boarding ____ Canoeing

____ Crafts ____ Horse shoes ____ Horseback riding

____ **Sailing** ____ **Swimming** ____ **Water skiing**

____ **Other:** ____

_

<u>FAMILY PHYSICIAN/PAEDIATRICIAN</u> (must be filled in):

Name ________________________________ Office # (___) ______________

Address ____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted on page 4.

Physician's Signature ____________________________ Date ________________

OPHTHALMOLOGIST (must be filled in):

Name ________________________________ Office # (___) ______________

Address ____

GUIDE DOGS: It is the camper's responsibility to feed, exercise and clean up after their dog.

IMPORTANT: Our camp is smoke-free. There is a zero-tolerance policy for alcohol and illegal drug use. Firearms, weapons or explosives are not allowed at camp. Sexual promiscuity is not allowed at camp.

2018 CAMP PUGWASH BLIND CAMP
CONSENT, RELEASE AND AUTHORIZATION

I hereby give my consent for ____________________________________ (name of applicant) to attend camp from June 24 - June 29, 2018.

In case of accident, illness, or death, I will not sue the camp, or its management.

This health history is correct as far as I know, and applicant has permission to engage in all camp activities, except as noted. In the event I cannot be reached in an emergency, I give permission to the physician, selected by the camp first aid attendant/adult leader in charge, to authorize any treatment necessary.

_____________ (Guardian/parent initials)

Camp Pugwash will be notified 3 weeks prior to camp if the applicant has been exposed to a communicable disease.

I understand that campers may be photographed for use by news media, publications or promotion. I consent for Camp Pugwash to use, in any manner, all photographs and recordings made.

This applicant is legally blind.

Signature _________________________________ **Date** ___________________

_

Relationship to applicant ____

_

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Office Use Only

Approved ____ Yes ____ No

Reason ____

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