

“going beyond the disABILITY”

# CAMPER'S APPLICATION



Presented By:  
**Ability Project**

*THE NEW  
'NORMAL'*

*...taking our relationship  
with GOD to a HIGHER  
LEVEL!*

## Encounter Jesus

at a summer escape for people with  
intellectual & physical disabilities

August 17-20

AT LAKE WILLIAMSON

Lake Williamson Road

Carlinville, IL 62626

**FOR MORE INFORMATION:**

Visit [www.Ability-Project.com](http://www.Ability-Project.com) or contact Pastor Jerry & Rebecca Fields

[fields.calvary@gmail.com](mailto:fields.calvary@gmail.com) 309.360.3717

# CAMP ABILITY APPLICATION INSTRUCTIONS

## GUARDIANS: KEEP THESE FORMS FOR YOUR RECORDS

**TUITION OF CAMP is \$275. NON-REFUNDABLE DEPOSIT of \$50 is required with Camper Application. Please only send exact tuition amounts. The remaining balance is due at registration.**

- **REGISTRATION starts at 8:30am on Tuesday, August 17<sup>th</sup>, and closes at 12 noon.**
- **It is critical to have PINK MED FORM filled out before arriving to registration!**
- **ALL GUEST APPLICATIONS must be postmarked by July 24<sup>st</sup>.**
- **CAMP CLOSSES at 12:00pm Friday, August 20th.**
- **LUNCH will be served on the first and last day of camp.**
- **ALL CAMPERS must be off the grounds by 1:00pm on Friday August 17th.**
- Please be sure your **TRANSPORTATION** is punctual.

Make checks payable to **Ability Project Ministry** and mail to:  
**'Camp Ability' 432 N. Linwood Dr. Galesburg, Illinois 61401**  
Or make payments online at **Ability-Project.com**

### Check list: (Please complete each step, this will save a lot of extra work)

- Have you read the entire application?
- Have you completed the application and attached any additional information you consider pertinent?
- Have you included a copy of your **Medical Assistance** and/or **Medicare card? (Required)**
- Have you included all the application pages together? **GUARDIAN AND PHYSICIAN SIGNATURES MUST BE ORIGINALS. No copies. Incomplete applications cannot be processed.**
- Has your **physician completed** and **signed** the Medical Form of the application?
- Have **PINK MED FORM** completed and bring to registration. (Or your check in will be delayed)
- Please include **a picture** of the guest with the application (no bigger than 4" X 6" or copy ID) **(required)**

**ALL CAMPERS MUST HAVE A MEDICAL EXAMINATION** within twelve (12) months prior to the date of Camp Ability. Each camper must complete the 2021 Medical Form as part of this application. Substitutions of this form will not be accepted, however additional information is appreciated. **All medications must be blister packed and OTC drugs must be in original bottles clearly marked for content, dosage, and frequency.** All medical and behavioral incidents will be documented. Applicants over 50 lbs needing transfers should expect to be lifted with the help of mechanical assistance **which you must provide.** Behavioral, food, etc. charting will not be done. Only medication charting will be recorded. Camp Ability programming takes precedence over any individual planned programming.

**APPLICANTS UNDER THE AGE OF 10** must be accompanied by a parent/guardian. A spouse or parent/guardian providing applicant's care may accompany him/her at no charge and must complete and submit a staff application

If you are **PROVIDING YOUR OWN CAREGIVER**, their completed staff application must be submitted with yours.

**ACCEPTANCE** to Camp Ability is not guaranteed. We reserve the right to refuse acceptance of applicant based on our ability to provide adequate care in conjunction with applicant's needs with regard to our programming. Pre-registration is required. An acceptance letter will be mailed two weeks prior to the date of Camp Ability. If applicant is not accepted, a full refund will be given.

**TRANSPORTATION** to and from the grounds is the applicant's responsibility.

## **DRESS CODE:**

- Shorts can be worn during the day. Absolutely **NO spandex shorts, boxer shorts, or shorts shorter than 2” above the knee.**
- Abbreviated attire such as half shirts, tank tops, spaghetti straps or crop shirts will not be allowed, and should be left at home.
- Shirts and dresses that have ANY part of the back missing will not be allowed. **NO oversized armholes or sides cut out of shirts.**
- Tight fitting clothing (pants and shirts) should be left at home. If you bring it, you will be asked to change. **ALL CLOTHING MUST BE MODEST.**
- Dark clothes and shoes must be worn for water sports.
- Shoes must be worn at all times.

## **GENERAL INFORMATION AND POLICIES –**

- VISITORS are welcome and should check in with the Ability Camp Director.
- All individuals must stay out of the halls and rooms of the opposite gender.
- No swapping of rooms. You must stay where you are assigned unless approved through the camp office.
- All items left at camp must be claimed within 2 weeks of camp attended.
- Multi-media players, firearms, knives, weapons, communicative devices or clothing and other articles displaying questionable content are NOT allowed. Cell phones are not allowed. Camp Ability will not be responsible for lost or stolen personal property.
- Fireworks, smoking, alcoholic beverages, or drugs are NOT allowed on the campgrounds.
- Public displays of affection are not allowed.
- We reserve the right to inspect all personal belongings. The holding and/or disposal of improper contents are the right of the camp staff.
- Friends and family can write: Camper’s Name - Camp Ability c/o Lake Williamson Christian Center, PO Box 620, Carlinville, IL 62626. (Please allow 3-4 days for delivery.)

**CAMP PROPERTY DAMAGE** – Charges for items broken/damaged during camp will be billed to all parties/individuals involved.

**MEDICATION** – All prescription medications must be in blister packs and over-the-counter drugs must be brought in the original bottle to the camp nurse on the first day of camp in a zip lock bag with the camper’s name clearly marked on the outside. PLEASE make sure all meds for your camper are picked up from the nurse before you leave the campgrounds on Friday. Complete and bring **PINK MED FORM** to registration.

**INSURANCE** – Camp provides supplementary insurance for those injured at camp.

**WHAT TO EXPECT AT CAMP** - Amenities include air-conditioned dorms, swimming pool, water sports, and more. Daily activities include special assemblies, awesome services, recreation and more. There is a concession stand and camp store filled with ice cream, candy, soft drinks, t-shirts, and novelties. Recommended allowance is \$4 - \$10 per day per guest. Water is available for guests and staff at all times.

**ITEMS TO BRING** - Twin sheets, blankets, pillow, towels, toiletries, money (cash only), swimsuit, casual clothes, dark clothes and shoes that can be worn for water sports, your Bible, a bag for wet clothes, and a bag for dry clothes and anything else that will make your time comfortable. Please clearly label all items. Guests are responsible for personal belongings. **Camp Ability is not responsible for lost/stolen items.** Do not send irreplaceable items.

## **TELEPHONES –**

Lake Williamson Christian Center – 217-854-4820 (For emergency use only)

IL District Office – 217-854-4600

**NOTE:** Campers will not be allowed to use the phone or cell phones once they are on the campgrounds. The only calls accepted will be emergency calls. If an emergency should occur, call the camp at 217-854-4820.

[fields.calvary@gmail.com](mailto:fields.calvary@gmail.com) - [www.Ability-Project.com](http://www.Ability-Project.com) - 309-360-371

# 2021 Camper Application

## Camp Ability August 17 – August 20

### SUMMER ESCAPE FOR PEOPLE WITH DISABILITIES

Full Ability Camp tuition is \$275. Non-refundable deposit of \$50 or full amount is required with application.

The remaining balance is due at registration on the first day at camp.

**Applications must be postmarked by July 24th!**

**Guardians must complete & return pages 4 - 9 of Camper Application.**

Office Use Only	
Room	_____
CG	_____
CoCG	_____
TL	_____
Med Staff	_____
Pd	_____ Ck# _____
Online	_____ Schol _____ Bal _____
Emer	_____ Med Form _____
Phys	_____ Guar _____
Allergies	_____

Last Name		First Name	Preferred Name (If different from First Name)	
Address			Phone Number	
City		State	Zip Code	
Date of Birth (mo/day/yr)	Age	Sex (M/F)	Email Address	
Parent/Guardian Name		Parent/Guardian Phone Number		
Relationship				

### Free Camp T-shirt: Shirt Size? S M L XL 2X 3X 4X (Please circle your size)

\_\_\_\_\_ Foster Home    \_\_\_\_\_ Institution    \_\_\_\_\_ Live in own home/apt    \_\_\_\_\_ Live with parent/guardian

\_\_\_\_\_ I am my own guardian    \_\_\_\_\_ Residential Facility/Group Home Name \_\_\_\_\_

Father or Guardian name: \_\_\_\_\_ Phone # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Mother or Guardian name: \_\_\_\_\_ Phone# \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_

If there is a concern with releasing this camper to anyone, please call. \_\_\_\_\_

Home Church \_\_\_\_\_ City \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

### CAMPER'S INSURANCE INFORMATION

#### The following information MUST BE COMPLETED:

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insured \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip code \_\_\_\_\_

FILL OUT PART 1 IF CAMPER HAS **ONLY A PHYSICAL DISABILITY**. FILL OUT PART 2 IF CAMPER HAS **ONLY AN INTELLECTUAL DISABILITY**. IF CAMPER HAS **BOTH DISABILITIES** FILL OUT PART 1 & PART 2

**PART 1: Camper has ONLY a physical disability**

DIAGNOSIS

- Brain Trauma
- Cerebral Palsy
- Multiple Sclerosis
- Muscular Dystrophy
- Spinal Bifida
- Spinal Cord Injury

OTHER FACTORS

- Uses Sign Language
- Hearing Impaired
- Sight Impaired
- Other – explain: \_\_\_\_\_
- Non-Verbal
- Uses Hearing Aids
- Will Bring Service Dog
- Deaf
- Blind
- Cannot climb stairs

SELF HELP AND SUPERVISION NEEDED

- Lives independently – No assistance needed
- Will require assistance from Camp Ability staff
  - Minimal
  - Moderate
  - Complete Care
- Will provide my own caregiver \*  Male\*\*  Female\*\*

Fill in information for caregiver who is providing care for camper

Name\* \*\* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**\*Caregiver's completed staff application must be submitted with this application.**

**\*\*Unless related, caregiver must be of same sex as guest.**

**PART 2: Camper has ONLY an intellectual disability**

INTELLECTUAL ABILITY

- High Functioning
  - Mild
  - Moderate
  - Severe/Profound+
- +Current programs are not designed for people with Severe/Profound intellectual disabilities.

OTHER FACTORS

- Non-Verbal
- Uses Sign Language
- Hearing Impaired
- Deaf
- Uses Hearing Aids
- Downs Syndrome
- Sight Impaired
- Blind
- Cannot Climb Stairs
- Autistic Behavior – describe \_\_\_\_\_

SELF HELP AND SUPERVISION NEEDED

- Lives independently
- Needs minimal supervision
- Requires Complete 1 on 1 Care**
- Wheelchair manipulation
- Poor behavior – explain: \_\_\_\_\_
- Will provide own caregiver \*  Male\*\*  Female\*\*

Fill in information for caregiver who is providing care for camper

Name\* \*\* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**\*Caregiver's completed staff application must be submitted with this application.**

**\*\*Unless related, caregiver must be of same sex as guest.**

**Please check the most appropriate statements in each category**

**SKILL EVALUATION**

MOBILITY

- Walks alone
- Needs assistance
- Uses and will bring:
  - Walker
  - Electric wheelchair
  - Can manipulate wheelchair alone
  - Paraplegic
  - Bears own weight
  - Uses Hoyer lift (Campers unable to transfer alone will be lifted with mechanical help.)
  - Slow
  - Braces
  - Crutches
  - Manual wheelchair
  - Cannot manipulate wheelchair alone
  - Quadriplegic
  - Transfers alone
  - Medium
  - Cannot walk
  - Fast

**(YOU MUST BRING YOUR OWN EQUIPMENT.)**

## SKILL EVALUATION (continued)

### EATING

- Independent – needs no assistance
- Needs assistance with \_\_\_\_\_
- Dependent, must be fed (Please provide a week's supply of disposable bibs & straws if needed)
- Has difficulty swallowing  solids  liquids  must use straw (Please send supply for week)
- Appetite  large  medium  small  limit helpings
- Allergic to foods listed: \_\_\_\_\_
- Diet restriction that CANNOT lapse during camp: \_\_\_\_\_

*(We are unable to provide specialized charting or diet for each applicant due to a camp type environment. If you cannot be tolerant in this area, YOU must provide special dietary foods (i.e., sugar free food and drink. Refrigeration and special preparation of foods is NOT available.)*

### COMMUNICATION

- No difficulty
  - Has difficulty
    - Expressing self
    - Understands directions and prompts
    - Slow to communicate needs
    - Difficulty understanding directions
    - Uses gestures
    - Non-verbal uses sign language (Please attach a description of signs)
    - Uses own language board (Please send with guest)
- Comments \_\_\_\_\_

### BEHAVIOR

- Generally happy (check all that apply)  Compliant  Social  Helpful  Cooperative
  - Generally unhappy (check all that apply)  Non-compliant  Withdrawn  Prone to depression
  - Does well in large groups  Does NOT do well in large groups
  - Cautious/Shy  Wanders (Note: guest who wanders off may be sent home for safety)
  - Physically Abusive/Aggressive  to self  to others  to staff
  - Adapts to new environment  quickly  slowly
  - Autistic behavior – describe: \_\_\_\_\_
  - Other behaviors – explain: \_\_\_\_\_
- Are there any behavior problems you handle in specific ways and would like us to continue?  
\_\_\_\_\_

*We ask this because we will try to be consistent with expectations and discipline at home if verbal instructions are inadequate.*

### SELF CARE & DRESSING

- Independent – needs no assistance
- Assistance is needed because applicant is  slow  needs prompts
- Cannot dress self without assistance. Please explain: \_\_\_\_\_
- Totally dependent
- Needs help with personal hygiene. Describe assistance needed: \_\_\_\_\_
- Usual bedtime \_\_\_\_\_ Usually awakens at \_\_\_\_\_
- Special sleeping habits \_\_\_\_\_
- Written instructions for specific care needs are listed on a separate page.

### TOILET NEEDS – Send adequate for needs

**You MUST bring your own shower/toilet chair if needed**

- Independent – needs no assistance
- Needs assistance with \_\_\_\_\_
- Totally dependent  Catheter  Colostomy
- Uses Depends/Diapers  at all times  only at night (bring enough for the entire week)
- Incontinent  bowel  bladder (Depends will be used)
- Wets bed (Supply adequate bedding, clothing, and/or Depends as laundry is not done during camp)
- Female guest is able to care for self during menstruation:
  - Fully  Partially  Not at all  Expected during week

### ACTIVITIES

- Independent – needs no assistance
- Needs assistance in some activities:  Arts/crafts  Sporting/Recreation
- Dependent for all activities
- Water sports:  Not allowed  Swims shallow  Swims deep
- Uses flotation  Does not swim  Afraid of water

Activities camper enjoys \_\_\_\_\_  
Recreational activity camper cannot participate in \_\_\_\_\_

## CAMP ABILITY CAMPER APPLICATION RELEASE FORM 2021

I give permission as legal guardian for the camper to attend Camp Ability. To the best of my knowledge, all signatures and information in the application are/is correct and the person herein described has my permission to engage in all activities, except as noted by myself and/or physician. I further understand that Camp Ability reserved the right to reject any applicant whose needs cannot be met by staff.

I understand that due to specific state laws and Camp Ability policy, ALL medications, whether prescription or non-prescription, brought to Camp Ability MUST be in blister packs or original container/prescription bottle, clearly marked with the name, dosage, frequency, times, and prescribing physician, and not in pre-poured containers, except for those pre-poured from a pharmacy, with prescribing physician and pharmacy clearly identified. Camper will not be allowed to stay if this is not followed. I agree not to send applicant if exposed to a contagious disease within three weeks of the event, and I will notify Camp Ability if guest must cancel. No one will be denied attendance at Camp Ability because of religion, creed, national origin, sex, age or disability.

**Emergency Consent:** I, the undersigned, parent or legal guardian of the applicant, do hereby authorize the director or responsible medical staff acting on behalf of Ability Project, to act as my Agent, to consent to medical, surgical or dental examination and/or treatment. In the event I cannot be reached in an EMERGENCY, please contact the emergency contact person listed on camper's application. I give permission to the Health Care Professional selected by the Camp Ability staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery. I assume financial responsibility for any medical treatment not covered by Camp Ability insurance.

**Discipline/Property Consent:** I understand that Ability Project and the rented facility make rules and guidelines that camper will abide by while attending camp. I understand that if guest misbehaves and does not respond in a positive manner when warnings are given, I may be called to pick him/her up and no refund will be issued. In addition, **I will pay for any damage that is done to the camp or to personal property belonging to another individual.** I give permission to the camp director and/or assistant camp director to inspect the contents of any or all of camper's personal belongings, and to withhold and/or dispose of any improper or illegal contents.

I understand that individuals are prohibited from carrying any weapon, as defined by state and local law, and including, but not limited to: handguns, firearms, "electric weapons" identified as any device which is intended to be used to immobilize or incapacitate persons by the use of electric current, a knife, a Billy club, or any other implement that is fashioned, designed, or intended to be used as a weapon, at any Ability Project events. I also realize that tobacco, alcohol and drugs (except those administered by medical staff) are not allowed at Camp Ability.

**Waiver of Liability:** I release and hold harmless Ability Project Ministry, its board of directors, staff, leadership, and volunteers, from liability due to negligence by Camp Ability staff, leadership and volunteers. I shall bring no claims, demands, or litigation against Ability Project Ministry for losses due to bodily injury, death or property damage arising out of or related to participation at Camp Ability.

**Disclaimer, and Permission:** I, the parent or guardian of the applicant, acknowledge that participation in all camp-related activities necessarily involves risk of physical injury. I further acknowledge that the programs of Ability Project are primarily administered by adults, who volunteer their time. I attest that applicant is physically capable to participate in this event. However, should directors, representatives, medical staff or volunteers determine in their sole discretion that participation in any games or events would be injurious to camper's health, or should camper become ill or injured, I consent to his or her removal from that activity and/or treatment by any physician or medical care provider at the direction of the Camp Ability director. I give my permission for free use of any videotape, photographs, audiotapes, or any other visual or audio reproduction in which camper may appear by Ability Project. I release Ability Project from any liability connected with the use of picture or voice recording as part of any promotion.

The information contained in this application is correct, to the best of my knowledge. I have read, understand, and agree to the above statement and agree with the aforementioned terms and conditions subject to attending Camp Ability.

Signature of Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

*Or Camper signature if own legal guardian*

*(Applications cannot be processed without proper signatures)*

**A CONFIRMATION OF ACCEPTANCE WILL BE SENT TWO WEEKS PRIOR TO CAMP.**

**MAIL COMPLETED APPLICATION WITH GUARDIAN'S SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:**

**Make checks payable to Ability Project Ministry and mail to:  
Camp Ability - 432 N Linwood Drive - Galesburg, Illinois 61401  
Or make payments online at [Ability-Project.com/camp](http://Ability-Project.com/camp)**

# 2021 MEDICAL FORM

No substitutions of this form will be accepted.

All campers must have a medical examination within twelve (12) months prior to date of Camp Ability.

**All prescriptions drugs MUST BE BLISTER PACKED. All over the counter drugs and inhalers must be brought to camp in the original bottle/container and turned into Camp Ability medical staff.**

Please place ALL meds inside a zip lock bag with camper's name clearly marked on the outside. A **PINK MED FORM** will be sent with acceptance letter to fill out and bring to registration. This prevents any delays!

**If a camper must have an inhaler with them at all times, a parent/guardian must complete the Medication Self-Administration consent form enclosed in this packet.**

The following information **MUST BE COMPLETED**:

Medical History for camper's Name: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Medical diagnosis of disability: \_\_\_\_\_

Explanation/Onset/Cause of disability: \_\_\_\_\_

Camper's current health condition: \_\_\_\_\_

Operations/Serious Illness – date & descriptions: \_\_\_\_\_

Chronic/Recurring Illness: \_\_\_\_\_

Camper has seizures:  No  Yes – frequency \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Controlled by medication:  No  Yes

Describe seizure \_\_\_\_\_

Activities camper should not participate in: \_\_\_\_\_

## ALLERGIES

Penicillin  Aspirin  Latex  Hay fever

Food allergy: \_\_\_\_\_  Other \_\_\_\_\_

## DISEASES/PAST ILLNESS

Diabetes  Asthma  Chicken Pox  Tuberculosis  Other: \_\_\_\_\_

Measles  Polio  Mumps  Whooping Cough \_\_\_\_\_

## IMMUNIZATIONS

Up-to-date  Yes  No

Tetanus date \_\_\_\_\_ HBV Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_

For guests 18 years & under, enter moth & year of each immunization:

DPT/DT/TD Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

Polio Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

MMR Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

HBV Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

Is there any information we should have regarding the welfare of this camper: handicaps, restrictions, diets, etc.? If this is not enough space, please attach a detailed sheet. \_\_\_\_\_

Is there any activity you do not wish him/her to participate in? \_\_\_\_\_

Please list all medications including prescriptions and/or over-the-counter drugs that will be taken at camp in the space provided below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PHYSICAN PERMISSION

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in Camp Ability functions through the end of the calendar year, except as noted above.

Physician's Name \_\_\_\_\_ City \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

*RN, LPN, QMRP signatures are NOT acceptable.*

MAIL COMPLETED APPLICATION WITH GUARDIAN'S SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:

**CAMP ABILITY 432 N Linwood Rd, Galesburg, IL 61401**  
**fields.calvary@gmail.com - www.Ability-Project.com - 309-360-3717**



# MEDICATION SELF-ADMINISTRATION CONSENT FORM

(INHALER and/or AUTO-INJECTABLE EPINEPHRINE)

Please complete this form if applies.

Camper's Name (Please Print) \_\_\_\_\_

Type of inhaler \_\_\_\_\_

**This form is good for camping year 2021.** This consent form must be updated anytime the camper's medication order changes and renewed each year.

The following must be provided for the camper to be eligible to self-administer rescue inhalers and/or auto-injectable epinephrine. Eligibility is **only** valid for this camp for the current year.

- a written statement from a licensed health-care provider who has prescriptive privileges that he//she has prescribed the rescue inhaler and/or auto-injectable epinephrine for the camper and that the camper needs to carry the medication on his/her person due to a medical condition;
- the specific medications prescribed for the camper;
- an individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing asthma and/or anaphylaxis episodes of the camper and for medication use by the camper during camp hours; and
- a statement from the prescribing health-care provider that the camper possesses the skill and responsibility necessary to use and administer the asthma inhaler and/or auto-injectable epinephrine.

If the camp nurse is available, the camper shall demonstrate his/her skill level in using the rescue inhalers and/or auto-injectable epinephrine to the nurse.

Rescue inhalers and/or auto-injectable epinephrine for a camper's self-administration shall be supplied by the camper's parent or guardian and be in the original container properly labeled with the camper's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Campers who self-carry a rescue inhaler or an epinephrine auto-injector shall also provide the camp nurse with a rescue inhaler or an epinephrine auto-injector to be used in emergency situations.

My signature below is an acknowledgment that I understand that Camp Ability and constituents, shall be immune from civil liability for injury resulting from the self-administration of medications by the camper named above and that the camper is agreeing to maintain the inhaler and not allow any other person to use it.

Parent or legal guardian signature \_\_\_\_\_

Date \_\_\_\_\_