



The Arc of Medina County

SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. / THE ARC OF MEDINA COUNTY  
4283 Paradise Road + Seville, OH 44273 + 877.546.8568 or 330.722.1900  
Fax: 330.723.6695 + www.shc-medina.org

Services for Individuals  
with Disabilities

November 2, 2015

Dear Friends,

Executive Director  
Melanie A. Kasten-Krause

President  
Mike Cavey

Vice President  
Joe Harrison

Secretary  
Natalie Shiposh

Treasurer  
Michael Kisha

Trustees  
Leslie Berzansky  
Jay Mitzel  
Robert Montgomery  
Mark Shee  
Don Spickler  
Thomas Tulisiak, M.D.  
Linda Yoder

**CHRISTMAS AROUND THE WORLD MINI CAMP is scheduled for Saturday, December 19, 2015.** The mini-camp is for youth campers of school age, seven years old and up. **The camp will be held at The Link, which is adjacent to the SHC main office complex and Camp Paradise, from 9 a.m. until 5 p.m.**

Plans for the day include holiday themed activities, crafts and a visit from jolly St. Nick! **Be sure to return the "gift suggestion" form with your registration.**

If your camper did not attend summer camp or a respite camp at Camp Paradise in 2015, the Medical Record Form needs completed by a physician. Unless you indicate otherwise, we will use the current medical information on file dated 2015 for repeat campers.

Please review the enclosed packet *carefully* and note the deadlines. Please give detailed information regarding your camper's needs. This will help us provide a safe and fun-filled camping experience. **Fee must be paid in full prior to arriving at Mini Camp.** Application deadline is **December 4, 2015.**

A limited number of partial camperships are available. Please refer to the Request for Campership form enclosed in the packet. You may also be eligible for Family Resources or waiver funding. Contact your case manager at the Medina County Board of Developmental Disabilities, at 330-764-8988, Wayne County Board DD, at 330-345-6016 or Ashland County Board DD, at 419-289-0470.

**Important Medication Instructions:** Please bring all medications in their **original prescription bottle or pack**. Trained staff will administer medications. If camper is exposed to any communicable disease during the two weeks prior to camp, please notify us prior to attending camp.

Clearly label all belongings with name of camper. Do not bring money or other valuables. We do our best to ensure all articles are returned, but we cannot take responsibility for the loss of property. Upon check-in, we will label any items without campers' names.

**Checklist of items due by December 4, 2015:**

- **HOLIDAY MINI CAMP 2015** Registration Form
- \$25.00 Non-Refundable Deposit
- **Gift List Form**
- Medical Record Form completed by Physician
- PRN Form completed by Parent or Physician
- Parent/Guardian/Camper Consent Form
- Activities of Daily Living Form

If you have any questions, please contact Chandler Laux, camp manager, at 330-722-1900, ext.165, or email [camp@shc-medina.org](mailto:camp@shc-medina.org).

Your camper's participation will be confirmed by phone no later than December 14, 2015. We're looking forward to another fun-filled day at Camp Paradise!

Cordially yours,

Jessica Hazelkorn,  
Community Operations Manager

An affiliated  
chapter of



# Youth Mini Camp Registration Form – Due 12/4/15 Page 1

**SHC/The Arc of Medina County**  
 4283 Paradise Road, Seville, Ohio 44273 • 330-722-1900 or Toll Free: 1-877-546-8568

## Christmas Around the World Mini Camp for School Age Youth on 12-19-15

Name of Camper: \_\_\_\_\_  Male  Female

Camper's Address: \_\_\_\_\_  
Street City/State Zip

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Street City/State/Zip

**PLEASE INDICATE THE SESSION YOU WISH TO ATTEND:**

Check Appropriate Box	SESSION	RESPITE CAMP DATE	FEE
<input type="checkbox"/> Day Camp	Saturday, 9:00 a.m. to 5:00 p.m.	December 19, 2015	\$80.00
<input type="checkbox"/> Call for details on hourly respite option	Hourly Camp from _____ to _____	December 19, 2015	Call for rate

**A \$25.00 NON-REFUNDABLE DEPOSIT MUST** accompany the application upon return to reserve your space. Camp will be filled on a first-come, first-serve basis. *Refunds will only be given if no space is available or if service is not able to be provided.* **SHC accepts credit cards for camp fees. Call the SHC office, ext. 235, for more information. DO NOT PROVIDE CREDIT CARD NUMBERS ON APPLICATION FORMS.**

Amount of deposit submitted: \$ \_\_\_\_\_ (\$25.00 non-refundable deposit)

Indicate form of payment:  Check enclosed  Family Resources  Credit Card  
 Waiver – Call 330-722-1900, ext. 165 for information

Person, agency, or organization responsible for fee: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City/State Zip

Return registration forms with deposit to: SHC/The Arc of Medina County  
 Mini Camp  
 4283 Paradise Road  
 Seville, Ohio 44273

**\* Fee must be paid in full prior to arriving at Camp.**

**Camper's Name:** \_\_\_\_\_

Email address: \_\_\_\_\_

**My Guardian's Name is:** \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

(# where you can be reached in case of an emergency)

Other Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**My Contact Person is:** \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

(# where you can be reached in case of an emergency)

Other Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**My Case Manager's Name is:** \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

**My Physician's Name is:** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax number: \_\_\_\_\_

---

Please describe camper's disability/special needs: \_\_\_\_\_

Camper's Allergies: \_\_\_\_\_

List some of the activities that the camper enjoys. \_\_\_\_\_

Describe any behavioral concerns (i.e. temperature, storms, bugs, dogs, crowds, loud noise, etc.). \_\_\_\_\_

Describe any special considerations that would help make Camp a good experience (i.e. special phone calls, etc.): \_\_\_\_\_

Describe any personal care needs that the camper has. \_\_\_\_\_

Any additional comments or suggestions: \_\_\_\_\_

---

---

Camper's Name: \_\_\_\_\_

**INFORMATION:**

- \_\_\_ Individual Plan (IP)- if the camper has an IP, send a copy of the Individual Plan
- \_\_\_ Behavior Plan- if the camper has a behavior plan, send a copy of the Behavior Plan.

**EATING/DRINKING:**

- \_\_\_ Independent
- \_\_\_ Needs food cut up into bite size pieces
- \_\_\_ Needs food cut up into smaller than bite size
- \_\_\_ Needs pureed foods
- \_\_\_ Needs liquids thickened
- \_\_\_ Difficulty swallowing
- \_\_\_ Must be fed
- \_\_\_ Uses special utensils and/or plate

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIET:**

- \_\_\_ Normal
- \_\_\_ Knows limits
- \_\_\_ Low calorie diet – Total calories \_\_\_\_\_
- \_\_\_ Diabetic – Total calories \_\_\_\_\_
- \_\_\_ Low salt/ No added salt

List food restrictions: \_\_\_\_\_

\_\_\_\_\_

List food allergies: \_\_\_\_\_

\_\_\_\_\_

**ADAPTIVE EQUIPMENT:**

- \_\_\_ Glasses
- \_\_\_ Contacts
- \_\_\_ Hearing Aid
- \_\_\_ Dentures
- \_\_\_ Wheelchair
- \_\_\_ Walker
- \_\_\_ Communication device: \_\_\_\_\_
- \_\_\_ Other (list) \_\_\_\_\_

**SLEEPING:**

Camper is used to \_\_\_\_\_ hours of sleep.

- Yes  No Camper can sleep on top bunk bed
- \_\_\_ No special concerns
- \_\_\_ Gets up during night
- \_\_\_ Occasional nightmares
- \_\_\_ Sleepwalks
- \_\_\_ Must be turned during the night
- \_\_\_ Requires bed rails
- \_\_\_ Has special night routine: \_\_\_\_\_

**DRESSES/UNDRESSES:**

- \_\_\_ Independent
- \_\_\_ Needs partial assistance
- \_\_\_ Needs total assistance

Explain: \_\_\_\_\_

\_\_\_\_\_

**BATHROOM:**

- \_\_\_ Independent
  - \_\_\_ Requires prompting for toileting
  - \_\_\_ Uses urinal
  - \_\_\_ Requires assistance with menstrual care
  - \_\_\_ Needs assistance wiping
  - \_\_\_ Uses toilet chair
  - \_\_\_ Needs transfer to toilet
  - \_\_\_ Needs total assistance
  - \_\_\_ Bladder incontinence
  - \_\_\_ Bowel incontinence
  - \_\_\_ Uses special undergarments
  - \_\_\_ Prompting schedule: \_\_\_\_\_
- \_\_\_\_\_

**BATHING:**

- \_\_\_ Independent
- \_\_\_ Needs partial assistance
- \_\_\_ Needs total assistance
- \_\_\_ Uses shower chair

**MOBILITY:**

- \_\_\_ Walks independently
- \_\_\_ Walks: Needs assist w/ slopes, rough areas
- \_\_\_ Wheelchair: Independent
- \_\_\_ Wheelchair: Assist w/ slopes, rough areas
- \_\_\_ Wheelchair: Needs assist at all times
- \_\_\_ Electronic Wheelchair
- \_\_\_ Wheelchair: Long distances only
- \_\_\_ Requires rest during the day

**TRANSFERS:**

- Camper weighs: \_\_\_\_\_ lbs.
- \_\_\_ Can transfer their weight independently
- \_\_\_ Pivot transfers/can bear weight on feet
- \_\_\_ Must be lifted \*

Please explain: \_\_\_\_\_

\_\_\_\_\_

Camper's Name: \_\_\_\_\_

**IN CASE OF EMERGENCY:**

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

If the first emergency contact person cannot be reached, contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

**Consent**

- Yes**    **No**   In an emergency, I hereby authorize Camp Paradise to seek medical or surgical care for the camper.
- Yes**    **No**   In the event non-emergency care is necessary, I hereby authorize Camp Paradise to contact Physician of Record.
- Yes**    **No**   I hereby give permission for the Camp Director or authorized SHC personnel to administer the Camper's Medication as listed on the Medical Record Form and PRN Sheet.
- Yes**    **No**   I give permission for the camper to participate in: a supervised swimming program at Camp Paradise which may include time in the hot tub (no more than 15 minute sessions).
- Yes**    **No**   **If yes, is the camper required to wear a lifejacket of floatation device while in the pool?**  
*\*Please note that Camp Paradise requires all individuals with a history of seizures to wear a lifejacket while in the pool for safety reasons.*
- Yes**    **No**   I hereby give permission for camper to be transported by camp staff for outings with Camp Paradise.
- Yes**    **No**   I hereby give permission for camper to be photographed or videotaped while engaging in activities involving Camp Paradise. I also consent to the public dissemination of this material for educational and promotional purposes.

**Notification of Incidents:** Parents/Guardians will always be notified in case of an emergency.

**Please check off the situations that you would like to be notified of:**

- Injuries NOT requiring first aid
- Injuries that require first aid (antibiotic ointment, ice, band-aid)
- Uncomplicated seizures
- Bee stings and insect bites
- Behavioral concerns

**Yes**    **No**   I give permission for notification of incidents to be left on my voice mail.

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

Camper's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for Pick Up:** Please be advised that for the safety of all campers, only persons listed on this form will be able to pick up your camper. You may be asked to provide identification at the time of pick up.

The following individual(s) are authorized to pick up my camper:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**TO BE COMPLETED BY A PHYSICIAN**

This form is required for all campers attending Camp Paradise. If the camper is taking prescription medication an exam must be performed within 6 months of the arrival at Camp. If the camper does not take medication this exam should be performed within 12 months of arrival at camp. We will also accept a copy of another examination signed by the camper's doctor if it is within these time frames and contains all of the information outlined below.

**PLEASE PRINT CAREFULLY**

Camper's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Please list **Allergies** if any: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICIAN STATEMENT – Must be filled out by a Physician**

\_\_\_\_\_  IS  IS NOT TAKING MEDICATION AT THIS TIME.  
 (Camper's Name)

TETANUS SHOT CURRENT (WITHIN LAST 10 YEARS): YES \_\_\_\_\_ NO \_\_\_\_\_

**ANY CHANGES IN MEDICATION AFTER DECEMBER 4, 2015 WILL NEED TO BE SUBMITTED ON A PHYSICIAN SIGNED ADDENDUM PRIOR TO STARTING CAMP.**

**IF CAMPER IS ON MEDICATION, COMPLETE THE FOLLOWING:**

Name of Physician prescribing medication: \_\_\_\_\_  
 (Please Print)

Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Camper is to take Medications while at Camp Paradise as follows:  
**Our medication administration times at camp are 8am, 12noon, 4pm and 8pm**

Name of Medication	Dosage and Frequency	Method of Dispensing (crushed, whole or in applesauce)

Medical Diagnosis: \_\_\_\_\_

History of Seizures  Yes  No If Yes, what type? \_\_\_\_\_

Please list all health concerns which should be known by camp staff: \_\_\_\_\_

**I certify the above applicant is fit to participate in the Camp Paradise program and is free of communicable disease:**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*PLEASE RETURN THIS FORM ALONG WITH PHYSICIAN SIGNED PRN MEDICATION SHEET BY DECEMBER 4, 2015\***

**TO BE COMPLETED AND SIGNED BY A PHYSICIAN, PARENT OR GUARDIAN**

THIS IS A REQUIRED FORM FOR THE RESPITE CAMP PROGRAM

**CHRISTMAS AROUND THE WORLD MINI CAMP on DECEMBER 19, 2015**

Camper's Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

The following are approved PRN medications, which may be utilized for common ailments unless contraindicated. We do utilize Sun Block with Aloe; please note if any of these products are contraindicated:

Symptom	Medication	Dosage
Headache, Pain, Fever	Acetaminophen	Per product recommendation based on camper's age and weight.
Muscle Aches, Menstrual Cramps	Ibuprofen	Per product recommendation based on camper's age and weight.
Nasal Congestion	Phenylephrine	Per product recommendation based on camper's age and weight.
Sore Throat	Chloraseptic	Per product recommendation based on camper's age and weight.
Stomach Ache, Indigestion	Riopan Plus	Per product recommendation based on camper's age and weight.
Diarrhea (liquid, watery, foul smelling stool)	Loperamide	Per product recommendation based on camper's age and weight.
Sun Protection	SunBlock SPF #30	Topically to exposed areas as needed
Sunburn	Aloe	Topically to affected areas as needed
Dry Skin	Moisturizing Lotion	Topically to affected areas as needed
Cuts, Abrasions	Bacitracin Ointment	Topically to open area 1 – 3 times daily as needed
Rash, Insect Bites, Itching	Benadryl and/or Caladryl Lotion	Per product recommendation based on camper's age and weight.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS IS A REQUIRED FORM - DUE DECEMBER 4, 2015**

Please bring the following items to respite camp in a backpack or tote bag. All clothing and other items that the Camper brings should be **clearly labeled with camper's name or initials**. Please do not bring money, food, towels, washcloths or electronic items. Please bring clothes that are appropriate for camp activities and the weather.

**Medication:**

- Medication (all medications must be in the original containers)
- Copy of the Medical Administration Record (if applicable)

**Clothes:**

- Swimsuit
- Change of clothes (if needed)
- Incontinence Aids (if needed)
- Appliances or adaptive equipment (if needed)

**Optional:**

- Hairbrush
- Swim shoes

\*Please note that towels are provided by Camp.







## GIFT LIST

**PLEASE RETURN COMPLETED FORM BY 12/4/15  
WITH CAMPER'S REGISTRATION FOR  
CHRISTMAS AROUND THE WORLD  
MINI CAMP on 12-19-15**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Santa will be giving each camper a gift this year. Please list two gift items less than \$20 for Santa's elves to choose from.

1. \_\_\_\_\_

2. \_\_\_\_\_

**Please return this form with your completed camp packet by 12/4/15**  
or email this information to [camp@shc-medina.org](mailto:camp@shc-medina.org).

# Holiday Mini Camp

## Christmas Around the World

**Saturday, December 19, 2015**  
**9 a.m. to 5 p.m. | Camp Fee: \$80.00**

*A mini camp designed for school-aged youth  
with developmental disabilities*

Enjoy a day filled with holiday games, crafts and festivities  
from around the world, and a swim session at the pool!

NOTE: The mini camp will be held at The Link, which is adjacent  
to the SHC main office at 4283 Paradise Rd., Seville, OH

For more information or to have a camp packet mailed to you,  
contact the camp director at 330-722-1900, ext. 165,  
or email at: [camp@shc-medina.org](mailto:camp@shc-medina.org)

**Deadline for registration is December 4, 2015**



4283 Paradise Road | Seville, OH 44273  
330-722-1900 | [www.shc-medina.org](http://www.shc-medina.org)

An affiliated  
chapter of

