



OPTIMIST CHILDREN'S CAMP

July 28 - August 3, 2019

Red Lodge, MT

Please visit our website for camp information, updates, photos, and additional camp applications.

www.optimistchildrenscamp.org
www.facebook.com/optimistcamp

Camp Director: Kaylee Bradley (406) 697-9638
optimistcamp@yahoo.com

PLEASE RETURN THIS APPLICATION NO LATER THAN JULY 1st
Space is limited, and applications will be reviewed and processed in the order in which they are received.

Mail to: **OPTIMIST CHILDREN'S CAMP**
C/O Kaylee Bradley
829 Custer Ave
Billings, MT 59101

THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:

Completed Application Release Forms Medication Form (if applicable)

Billings Area Sponsoring Optimist Clubs:

Big Sky Optimist Club
Breakfast Optimist Club

Magic City Optimist Club
Heights Business Optimist Club

A \$50 voluntary contribution is asked this year to help cover rising camp costs. Please make checks payable to "Optimist Children's Camp" and include with your application.

Any additional donations would be appreciated to assist with camp costs.

OPTIMIST CHILDREN'S CAMP

(AGES 8-21)

July 28 – August 3, 2019

Name of Camper: _____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Gender: ___ Age: ___ DOB: _____ Present School: _____ Grade: _____

T-shirt size (adult sizes) Small _____ Medium _____ Large _____ XL _____ XXL _____

Parent's Name: _____

Address (if different from above): _____

City: _____ State _____ Zip Code: _____

**E-mail address: _____

Home Phone: (____) _____

Father's Work Phone: (____) _____ Cell Phone: (____) _____

Mother's Work Phone: (____) _____ Cell Phone: (____) _____

Alternate emergency contact: Name: _____ Phone: _____

Has your child attended the Optimist Camp before? YES NO

If YES, what was the last year attended? _____

Child's Developmental Delay: Mild _____ Moderate _____ Severe _____

Diagnosis: _____

MEDICAL INFORMATION (Please use additional paper if necessary)

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Other Medical Specialists: _____ Phone: _____

_____ Phone: _____

Date of last tetanus booster: _____

Insurance Company: _____ Policy #: _____

MEDICATION OR TREATMENTS

Medication	Dosage	Times

Current Health Conditions

___ High blood pressure

___ Seizure within last year

___ Allergic to bee sting

___ Back problems

___ Heart Problems

___ Sensitive to sun

___ Food allergies

___ Diabetes

___ Frequent nose bleed

___ Disorientation/memory problems

___ Asthma/Respiratory

___ Penicillin/Latex/other

Explanation of conditions above-attach additional pages if needed: _____

Does child have any special equipment that will be brought to camp? YES NO

If YES, please list: _____

PROSTHETICS OR BRACES (if applicable, when worn and directions on use):

WHEEL CHAIR: YES NO (IMPORTANT: Due to the accessibility of our camp facility, the nature of our activities, and our transportation methods used during the camp, we can no longer accept new campers who require full-time wheel chair use)

SEIZURES: YES NO (If yes, please describe type and frequency of seizures in detail): _____

ALLERGIES:

Medications: _____

Foods: _____

Other: _____

PLEASE LIST ANY OTHER SPECIFIC MEDICAL PROBLEMS (be detailed):

DOES YOUR CHILD HAVE ANY KNOWN FEARS (afraid of horses, water, etc.):

WHAT IS YOUR CHILD'S GENERAL PHYSICAL CONDITION: _____

ARE THERE ANY ADDITIONAL MEDICAL INSTRUCTIONS? _____

PERSONAL SKILLS (Please use additional paper if necessary)

EATING:

Special Diet: YES NO (If YES, Please list type of diet) _____

Is your child able to feed himself/herself: YES NO

Are there any foods your child refuses to eat? YES NO (if YES, please list):

Other instructions: _____

DRESSING:

Is your child able to dress himself/herself: YES NO Needs help with _____

Other instructions: _____

SLEEP:

At night sleeps from _____ to _____ Average hours _____

Naps from _____ to _____ Average hours _____

General attitude: _____

Does your child wet the bed? YES NO

Other instructions: _____

TOILETING:

Is your child able to go independently: YES NO

Does child indicate need: YES NO

What times is child usually taken to the bathroom: _____

Does child need supervision when in the bathroom: YES NO

Special devices: _____

Other instructions: _____

RECREATION:

Please list interests: _____

Please list dislikes: _____

Are there any activities your child cannot participate in: _____

What best describes your child at present: (Circle all that apply)

Mostly quiet	Talks constantly	Rocks self often	Difficulty learning new tasks
Restless	Easily frustrated	Wets bed	Poor attention span / concentration
Frequent tantrums	Tires easily	Over reacts	Has difficulty following directions
Overly active	Fights frequently	Cries often	Has nervous habits or ticks

Is your child non-verbal? YES NO How does he/she communicate? _____

Does child have a history of self-abuse, hand biting, head banging, etc.? YES NO

Does child have a history of aggression towards others? YES NO

What type of aggression? _____

Is aggression under control? YES NO

What other behaviors should we be aware of and how can we best address them? _____

RELEASE

I, (We) give permission for my (our) child to appear as a subject in film or photographic presentation for the private use of the sponsoring organization or the camp personnel.

In consideration of The Optimist Children’s Camp permitting my child to attend the camp, I hereby, and for(my) (and my child’s) heirs, executors, administrators, assigns, and all legal guardians, **WAIVE AND RELEASE ANY AND ALL RIGHTS AND CLAIMS OF ANY NATURE, FOUNDED IN WHOLE OR IN PART UPON ANY TYPE OF NEGLIGENCE** that (I) (and my child) may have against The Optimist Children’s Camp, its directors, officers, employees, counselors, volunteers, agents, chapters, assignees, licensees, and cooperating entities, their representatives, heirs, executors, administrators, successors, and assigns (the “released parties”) arising out of or resulting from any and all injuries or damages of any nature, including death, which my child may suffer while taking part in The Optimist Children’s Camp or any activities connected with the camp. **I UNDERSTAND THAT THIS MEANS THAT I AGREE NOT TO SUE ANY OR ALL OF THE RELEASED PARTIES IN CONNECTION WITH THE EVENT.** I further understand that I assume all risks in participating in The Optimist Children’s Camp. I further recognize that The Optimist or camp cannot be held responsible for personal injury, death, and loss of clothing or personal property while at camp, and I will have all belongings plainly marked.

This release shall be binding upon me/my (and my child’s) heirs, executors, administrators, assigns (and all legal guardians of my child)

Signature of Parent/Legal Guardian Date

Signature of Parent/Legal Guardian Date

EMERGENCY ROOM CONSENT TO TREAT

This consent is given for the period starting July 28, 2019 through August 3, 2019.

Permission is given to any physician or member of hospital staff to perform emergency treatment, and procedures for _____, as he/she deems necessary, and to continue until such time as the undersigned shall dismiss him/her or engage another physician. This permission includes admission to a hospital, if the attending physician deems it necessary.

Signature of Parent/Legal Guardian Date Witness Date

Signature of Parent/Legal Guardian Date Witness Date

(Only complete if applicable)

Request for Administration of Medication/Procedure For
Optimist Children’s Camp
July 28 – August 3, 2019

Name of Camper _____ DOB _____

I request that the camp nurse administer the medication/procedure described below. I understand that I need to have a physician’s order (included below) signed by the prescribing doctor for all medication/procedures to be completed during camp. I will send the medication in the original container or prescription bottle with the correct instructions labeled on it.

Signature of Parent/Guardian	Date	Phone
.....		

(LOWER PORTION TO BE COMPLETED BY DOCTORS OFFICE)

Physician’s orders for Medication/Procedure

Med Name or Procedure	Dosage	Time	Physician	Diagnosis

The above medication/procedure has been prescribed by me and is necessary for this child to take during the week of camp.

Physician’s Signature	Date	Phone

2019 Optimist Children's Camp
“OVER THE COUNTER” MEDICAL CONSENT FORM

*This form must be completed for all Campers and any Counselors under the age of eighteen (18).

I _____ authorize the Registered Nurses to administer
(Parent/Legal Guardian’s Name)
the following “Over-the-Counter” medications to _____
(Camper/ Minor Counselor Name)
as necessary while attending camp.

POSSIBLE LIST OF “OTC” MEDICATIONS:

1. Hydrocortisone Cream (Cortaid)
2. Antibiotic Ointment (Neosporin)
3. Ibuprofen (Motrin, Advil)
4. Acetaminophen (Tylenol)
5. Tums
6. Children's Senna Laxative Strips
7. Imodium Anti-diarrheal
8. Diphenhydramine (Benadryl) Oral or Topical
9. Loratadine (Claritin)
10. Cough Drops

*Please cross off and initial any medications the Registered Nurses would not be allowed to administer to Camper/Minor Counselor while attending camp. If there are any additional “OTC” medications not shown above that should not be administered, please list below:

(Parent/Guardian’s Signature)

(Date)