Dear Campers,

As COVID-19 continues to be a risk, we have decided to modify our services to safely serve our campers. We have established guidelines and modifications with our local health department's help while also seeking guidance from the Ohio Department of Health, Department of Developmental Disabilities, and the American Camping Association based on what we know today. We can almost guarantee that plans will change as guidance continues to evolve due to the virus. We ask you to be patient and prayerful with a heart to extend grace as our leadership team continues to make these decisions. As new and pertinent information becomes available, we will be sure to communicate it timely and accordingly.

The safety of all Camp Echoing Hills participants is paramount. To safely care for our campers, we have decided to set the following criteria for camp this summer. Unfortunately, we will be unable to serve participants at this time who demonstrate one or more of the following:

- Participants unable to stay with their group
- Requires services less than 4:1
- Participants unable to wear a mask or maintain safe social distancing
- Certain health conditions
  - Immunocompromising conditions (ex: HIV, cancer, post-transplant, prednisone treatment, etc.)
  - Participants with tracheostomies
  - Participants that typically attend our "Encounter Camp" week
  - Participants that demonstrate inappropriate behaviors that could cause harm to another individual
  - Severe self-injurious behavior
  - Refusal to participate in programming
  - Participants requiring oxygen

Please note, Camp Echoing Hills will not be accepting new campers for this summer. Camp Echoing Hills will also require all participants to have their medications pre-packaged by a pharmacy. Medication guidelines are included with this packet.

Again, please note that program dates are subject to cancellation if directed by state and local officials. If a cancellation is necessary, Camp Echoing Hills will notify families.

We look forward to a safe and exciting Summer Camp Season! For any questions regarding camp, please contact the camp staff directly. Our phone number is 740.327.0300. You can reach one of the following:

Lauren Unger ext. 1201  Emily Smith ext. 1211

Sincerely,

Lauren Unger
Camp Echoing Hills Administrator
Summer Camp Participant Application

Applicant’s Full Name ________________________________ Date of Birth _______ Age ______
Street Address ___________________________________________ City _____________________
State ___________ Zip ____________________ County ________________________________
Is applicant their own guardian?  Yes__ No__

Parent/Guardian Name _____________________________________Relationship ______________
Phone (_____)____________________ Cell Phone (_____)____________________
Parent/Guardian Address __________________________________________
City _____________________________ State __________ Zip _________
County _____________________________ Email____________________________
Parent/Guardian Place of Employment __________________________ Phone (_____)___________

Agency/Facility Serving Applicant _____________________ Phone (_____)____________________
House Manager _______________________ Contact after hours _____________________
Address ______________________________ City ________________ State __________ Zip 
__________ County _____________

HAS APPLICANT ATTENDED CAMP ECHOING HILLS BEFORE?  Yes ___ No ___ When? ______

Who should we contact if we have questions regarding this application?
Name _______________________ Best Contact # ___________________
Email____________________________________________

Where does applicant live?  ICF Home ____  Waiver Home ____  Private ____

Camp Weeks applying for: 1st Choice_____________________ 2nd Choice __________________

Purchasing a T-Shirt? Camp shirts can be ordered up until May 1st. T-Shirts will not be ordered for your camper without receiving payment by May 1st. Please see attached order form.
In Case of Emergency
We will attempt to contact Parent/Guardian first. Must List 2 additional contacts.

Name ________________________________  Name ________________________________
Relationship___________________________ Relationship___________________________
Work Phone ___________________________ Work Phone ___________________________
Home Phone __________________________  Home Phone __________________________
Cell Phone ____________________________ Cell Phone ____________________________

Applicant’s SS# _______________________ Medicaid # ___________________________
Medicaid Effective Date: ________________ Medicare # ___________________________
Applicant’s Insurance Company ____________________________ Policy # ___________________

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Pick up Authorization
I authorize my child/adult to be released/picked up only by the following persons. Please include parents if applicable. I will notify Camp Echoing Hills of any changes in this information.

Please do not leave this section blank

Name _______________________________ Relationship _________________________________
Name _______________________________ Relationship _________________________________

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How would you like to pay for your services?

Funding Contact/Service Facilitator/SSA Name __________________________________________
Funding Contact/Service Facilitator/SSA Email _________________________________________
Funding Contact/Service Facilitator/SSA Phone (____ )_________________________________

☐ Cash Payment
☐ Check or Money Order
☐ Local Lions Club
☐ County Contract

☐ Third Party Funding Source
   Please check the following
   ☐ Waiver Level One (L1)
   ☐ Waiver Independent Options (IO)
   ☐ Self Waiver

Waiver individuals have an additional $100 room and board fee that the waiver does not cover.

If you checked waiver:

1. Please provide the contact information above
2. Notify the SSA or County of intentions to enroll your camper at Camp Echoing Hills
3. Have funding source forward a copy of the annual plan to Camp Echoing Hills.

**Note: If you do not contact your SSA you may be billed for the entire camp fee.

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*Would you like to request a scholarship? Please contact us if you need a Camp Scholarship Form.*

We must have all necessary documentation for individuals on waivers. Those who do not provide all documentation will not be allowed to attend camp.
APPLICANT’S DISABILITY AND PRESENT CONDITION

Cause and onset of disability: At birth _______ Illness _______(year _____) Accident _____(year _____)

Please give diagnosis and fully describe the extent and degree of disability: ________________________
________________________________________________________________________________________
________________________________________________________________________________________

MEDICAL INFORMATION (please fill in all applicable information) Sex ____ Height ______ Weight ______

*DIABETES: Is Applicant Diabetic? : Yes ( ) No ( ) How is Diabetes being controlled? ______________
Applicant’s typical blood sugar range? ___________ Testing schedule?(How often) : ______________

Does applicants use a sliding scale? : Yes ( ) No ( ) Please send copy of sliding scale to camp if applicable.
Any additional information we should know pertaining to applicant’s diabetes? : ______________________
________________________________________________________________________________________
Note: Please send the necessary supplies for testing.

*Seizures and Convulsions
Does applicant have a history of seizures? Yes ( ) No ( ) If yes, how often? ______________
What type(s) of seizure does camper have? ______________ How long do they last? ______________

Please describe a typical seizure, medication used and precautions for reducing onset of seizures:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What are seizures triggered by?: ________ Please explain: ________________________________

Are there special precautions to be taken, such as wearing protective headgear? ______________________
Have seizures medications been changed recently? ______ Is there a protocol to be followed for frequent or
prolonged seizures?: ______ Please explain: _________________________________________________

*Allergies
Medication Allergies: ________________________________
Food Allergies: __________________________________
Other Known Allergies: ___________________________

Is applicant allergic to bee stings or other insect bites? Yes ( ) No ( ) If yes, please describe the
reaction and how it should be treated: _______________________________________________________

Does applicant use an Epi-pen? ______ What is Epi-Pen used for? ______________________________
Camp Echoing Hills does not provide Epi-pen injection supplies. Camper must bring any needed supplies,
properly labeled and identified.

*Medication Information
Does the camper experience any side effects from their medication i.e. mood behavior changes, upset
stomach, etc.? Yes ( ) No ( )
List below any special instructions or additional information regarding the medications that would be helpful to
Health Care Staff.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

How are medications given? With Water ___ With Juice ___ With Pudding ___ With Applesauce ___
Through G- Tube/J- Tube ___ Other ____________________________

Can applicant use acetaminophen for minor problems (headache, low grade fever)? ___________________
**Other Medical Information**

Does the applicant sunburn easily? Yes ( ) No ( ) If yes, list restrictions that apply: __________________________
________________________________________________________________________________________

Should applicant avoid exertion due to heart or other health concerns? ________________________________

Please describe other allergies, health concerns or sensitivities that may hinder applicant’s participation: ___
________________________________________________________________________________________

**Does the applicant have Asthma? Yes ( ) No ( )

What causes an asthma attack? ________________________________

What is your procedure following asthma attack? ________________________________

Please list asthma medications, inhalers, etc. and how they are used ________________________________
________________________________________________________________________________________

**Does applicant have bedsores, pressure areas or decubitus ulcers that are being treated? ___________

If yes, please specify location of area and describe treatment: ______________________________________
________________________________________________________________________________________

**Illnesses applicant has had: (please check all that apply)

Frequent Colds ( ) Fainting Spells ( ) Low Blood Pres. ( )
Frequent Sore ( ) Skin Rashes ( ) High Blood Pres. ( )
Throat Ear ( ) Heart Disease ( ) General Blood Pressure Range
Infections ( ) Breathing Problems ( )

Please explain any chronic or recurring illnesses, rashes or infections:

________________________________________________________________________________________

Applicant’s Physician’s Name ___________________________ Phone (_____)________________

Most recent physical exam, date and findings: ___________________________________________________
________________________________________________________________________________________

**MOBILITY** (please check all that apply)

Normal Walking ( ) Cane(s) ( ) Uses a Walker ( )
Slow Walking ( ) Crutches ( ) Hoyer Lift ( )
Unsteady Walking ( ) Wheelchair: Manual ( ) Legs Bear Weight ( )
No Walking ( ) Electric ( )
Braces ( ) When are they worn? ________________________________

Describe best way to transfer applicant from wheelchair: ___________________________________________
________________________________________________________________________________________

_Please note: Camp Echoing Hills cannot provide wheelchairs. All wheelchairs must have a safety belt to protect the applicant. Always check wheelchairs before an event to assure safe working order._

**EATING** (please check all that apply)

Eats independently ( ) Has trouble swallowing: Solid foods ( ) Liquids ( )
Needs help eating ( ) Needs to be fed: Some foods ( ) All food ( )
Needs food cut up ( ) Needs to eat: Mechanical Soft foods ( ) Pureed foods ( )
Uses straw for liquids ( ) Describe appetite: Poor ( ) Normal ( ) Overeats ( )
Uses gastronomy tube ( ) Thickened Liquids: ( ) Liquid Consistency __________________

Please describe any adaptive eating equipment: ____________________
________________________________________________________________________________________
Please describe any food allergies or food to avoid: __________________________________________
______________________________________________________________________________________

Other information regarding applicants eating habits: _________________________________________
______________________________________________________________________________________

*Please note: Camp Echoing Hills will modify diets if there is a specific medical need to do so. Every effort is made to monitor amounts served, but we may not be able to adhere to general weight restricting diets.

**SLEEPING ARRANGEMENTS** (please check all that apply)
Sleeps through night ( ) Sleeps with side rails ( ) Prone to bad dreams ( ) Wanders in the night ( )
Wets bed: Never ( ) Occasionally ( ) Frequently ( )

Please explain how bedwetting is handled: __________________________________________________
______________________________________________________________________________________

Other information on sleeping arrangements: ________________________________________________
______________________________________________________________________________________

**APPLICANT PERSONAL CARE AND HYGIENE** (please check all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Needs Help</th>
<th>Total Care</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Showering</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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</tr>
<tr>
<td>Washing Hands &amp; Face</td>
<td>( )</td>
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<td>( )</td>
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</tr>
<tr>
<td>Brushing Teeth</td>
<td>( )</td>
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<tr>
<td>Shaving</td>
<td>( )</td>
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</tr>
<tr>
<td>Washing Hair</td>
<td>( )</td>
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</tr>
<tr>
<td>Tying Shoes</td>
<td>( )</td>
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</tr>
<tr>
<td>Using Toilet</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Menstruation (women only)</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding personal care: ________________________________________________
______________________________________________________________________________________

**TOILETING NEEDS** (please check all that apply)

Uses: Portable urinal ( ) Bed pan ( ) Catheter ( ) Type __________________________
Uses: Briefs ( ) Plastic pants ( ) Liners ( ) When: Night only ( ) Occasionally ( ) Always ( )

If applicant has occasional constipation, how is it managed? ________________________________

Other information regarding toileting needs: ______________________________________________
______________________________________________________________________________________

**SWIMMING** (please check all that apply) *Note: Pool is only 5’ deep
- Swims independently ( ) Fears water ( ) Not allowed in pool at all ( )
- Needs life jacket ( ) Does not need Life jacket ( ) Seizure Prone in Water ( )
- Wears ear plugs ( ) Needs one-on-one attention in pool ( )

Please note: If applicant has toileting accidents or uses briefs, please send swim briefs. Disposable products may not be used in the pool.
I LIKE TO DO:
- Archery
- Paintball
- Go-Carts
- Board/Card Games
- Crafts
- Dancing
- Fishing
- Group Activities
- Nature Exploration
- Sensory Activities
- Singing
- Sports
- Swimming
- Other

I COULD BECOME UPSET BECAUSE:
- I am too hot or cold
- I am not getting my way
- I am being told "no"
- I am being asked to wait
- I am afraid
- I am being asked to take turns
- I am trying to communicate and am not being understood
- There is a change in my schedule
- Someone is bossing me around
- I am in a crowd
- I am ill / In pain
- I am hungry or thirsty
- I am asked to share
- Other

I COMMUNICATE BEST:
- Non Verbal
- Verbally
- Writing Notes
- Using sign language
- Using gestures/pointing
- Using simple words
- Using body language and facial expressions
- Using a communication device

** Will this be sent to camp? Yes ___ No ___

I DO NOT LIKE OR MAY BE AFRAID OF:
- Animals
- Change in schedule
- Insects
- Large Groups
- Loud Noises
- Nurses/Doctors
- Showers
- Storms
- The Dark
- Toileting
- Water
- Other

MY FRUSTRATIONS MAY APPEAR BY:
- Bad language
- Biting self or others
- Crying
- Hair pulling
- Hiding
- Hitting
- Kicking
- Inappropriate Touch
- Refusing to move
- Running away
- Scratching
- Screaming
- Spitting
- Throwing things
- Undressing
- Wandering
- Other

YOU CAN HELP ME BY:
- Offering Quiet space
- Offer me choices
- Speaking calmly and quietly
- Use fewer words
- Take a break
- Use picture schedule
- Provide pressure
- Provide sensory input
  (jumping, running, splashing)
- Talk to me about why I am upset
- Use first/then statements

I have a behavior plan ___ Yes ___ No
**(Must be sent prior to camp)**
I may exhibit sexual behavior: ___Yes ___ No
Explain_______________________________

____________________________________
REGISTRATION TIME FOR SUMMER CAMP IS DEPENDANT ON THE ASSIGNED CAMPER CABIN

PLEASE INITIAL AND SIGN:

- This application must be completed AND SIGNED in full and sent with the $70 application fee. This application is considered incomplete until the entire form has been filled out. Incomplete applications will be returned. Please include a picture of the camper for identification purposes. Initial _____
- Application MUST be signed by the applicant’s guardian if the applicant is not their own guardian. Initial _____
- Camp Echoing Hills does not provide medications or personal supplies. ALL MEDICATIONS MUST BE CHECKED IN AT REGISTRATION. Any items purchased will be charged to the applicant or payee. Initial _____
- Applicant assumes responsibility for any damages that they cause to persons or property. Initial _____
- Camp Echoing Hills is not responsible for any lost items. Please label all individual’s belongings accordingly. Initial _____
- Camp Echoing Hills provides 100% supervision while at camp. Initial _____
- Camper’s ISP must be sent to camp before camper attends camp week.(Waiver clients only) Initial _____
- I understand that there are new guidelines in place due to Covid-19 and applicant can/will adhere to the set guidelines for the time they are at camp. Initial _____
- I understand that as Covid-19 continues to be a risk program dates are subject to cancellation if directed by state and local officials. Initial _____

COMPLETE APPLICATIONS are due as soon as possible. We will not guarantee a spot until the completed application has been received. A completed application entails:

- Application Form (Completely filled out. Incomplete applications will be returned.)
- Individual Support Plan (ISP) if you are using your waiver to pay your camp fee.
- Behavior Support Plan (BSP) if applicable.

“I have read and understand the above listed unalterable terms. Applicant has my permission to attend and participate in the above named Camp activity. Camp Echoing Hills has my authorization to use the designated Camp physician for emergency treatment for the applicant. Medical information may be released by the attending physician as given on this application.”

Signature of Parent/Guardian ____________________________________________ Date ____________
(Or camper if own guardian)

** Please keep a copy of this form for your records.**