CRISTO VIVE CAMP APPLICATION FORM

Cristo Vive International • P.O. Box 527 • Big Lake, Minnesota 55309
Phone: 763-263-1526 • Email: cvi@cristovive.net • Website: cristovive.net

Please fill out on your computer, print, sign in required areas, and mail in to address above.

OSCEOLA, WISCONSIN

☐ June 13-17, 2010
☐ June 23-27, 2010

HARPSTER, IDAHO

☐ August 10-14, 2010

IDENTIFYING INFORMATION:

Applicant's Full Name: ______________________ Phone: ______________
Street Address: ______________________ Country: ______________
City: ______________________ State: ________ Zip Code: ______________
Sex: ☐ M ☐ F Height: ________ Weight: ________ Date of Birth: ________ Age: ________
Is the applicant attending school? ☐ Yes ☐ No Grade Level: ______________
Parent/Guardian: ______________________ Phone: ______________
Street Address: ______________________ Country: ______________
City: ______________________ State: ________ Zip Code: ______________
Place of Employment: ______________________ Phone: ______________
Additional Emergency Phone: ______________________ Phone: ______________
Agency/Facility Serving Applicant: ______________________
Street Address: ______________________ Country: ______________
City: ______________________ State: ________ Zip Code: ______________
Has the applicant attended a Cristo Vive camp before? ☐ Yes ☐ No

PERSONAL INFORMATION:

Please describe the applicant's disability, and the extent/degree of that disability:

____
____
____
____
____

FINANCIAL ARRANGEMENTS:

Who will be responsible for payment of the camp fee?

Name: ______________________ Phone: ______________
Street Address: ______________________ Country: ______________
City: ______________________ State: ________ Zip Code: ______________

Mission: *Provide children and youth with disabilities and their families with an opportunity to experience the love of God and faith in Christ through a fun and engaging camp adventure.*

Romans 8:16-17 *The Spirit Himself bears witness with our spirit that we are children of God, and if children then heirs — heirs of God and joint heirs with Christ, if indeed we suffer with him, that we may also be glorified together.*

MOBILITY & EQUIPMENT: (Please check all that apply)

☐ Normal Walking	☐ Cane(s)	☐ Walker
☐ Slow Walking	☐ Crutches	☐ Hoyer Lift
☐ Unsteady Walking	☐ Braces	☐ Legs bear weight
☐ No Walking	☐ Wheelchair - Manual	☐ Wheelchair - Electric

Please describe the best way to transfer the applicant from a wheelchair:

____

____

____

____

COMMUNICATION (Please check all that apply)

☐ Normal Speech	☐ No Speech	☐ Sign Language
☐ Impaired Speech	☐ Comm. Board	☐ Hearing Aids

Please identify any important word substitutes or sounds used by applicant:

____

____

____

____

____

SLEEPING ARRANGEMENTS: (Please check all that apply)

☐ Sleeps well	☐ Prone to bad dreams	☐ Wets bed often	☐ Bipap used

List any other sleeping information/concerns:

____

____

____

____

EATING: (Please check all that apply)

☐ Independent	☐ Trouble Swallowing	☐ Good Appetite
☐ Needs Assistance	☐ Uses a straw	☐ Normal Appetite
☐ Needs to be fed	☐ Needs food cut up	☐ Poor Appetite

Please describe any adaptive eating equipment:

____

____

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FOOD ALLERGIES:

___

___

___

Does applicant have Diabetes Mellitus? ☐ YES ☐ NO If YES, please specify type:

☐ Insulin dependent (please pack glucose monitor) ☐ Non-Insulin dependent

Specify dietary restrictions:

___

___

___

APPLICANT PERSONAL CARE & HYGIENE: (Please check all that apply)

Dressing: ☐ No help needed ☐ Needs help ☐ Total Care Add'l Info:___

Showering: ☐ No help needed ☐ Needs help ☐ Total Care Add'l Info:___

Wash Hands: ☐ No help needed ☐ Needs help ☐ Total Care Add'l Info:___

Brush Teeth: ☐ No help needed ☐ Needs help ☐ Total Care Add'l Info:___

Toileting: ☐ No help needed ☐ Needs help ☐ Total Care Add'l Info:___

Other personal care information:

___

___

___

___

PERSONALITY & BEHAVIOR INFORMATION: (Please check all that apply)

☐ Sociable ☐ Friendly ☐ Cooperative ☐ Helpful

☐ Sensitive ☐ Aggressive ☐ Self-Abusive ☐ Withdrawn

☐ Homesickness ☐ Bad Temper ☐ Shy ☐ Complains

Please explain any of the above. Describe any other unusual behavior and behavior modification techniques:

___

___

___

___

___

___

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PROGRAM INFORMATION:

What kind of activities does the applicant enjoy?

____

____

What kind of activities does the applicant NOT enjoy?

____

____

Please list any general concerns about application's participation in camp activities:

____

____

____

MEDICAL INFORMATION:

Applicant's Physician's Name: ____

Clinic/Hospital _______________________________ Phone _______________________

****** Please include a copy of applicant's Medical Insurance card ******

Illnesses Applicant HAS had:

☐ Measles ☐ Chicken Pox ☐ Mumps

☐ Scarlet Fever ☐ Frequent Colds ☐ Sore Throat

☐ Ear Infections ☐ Fainting Spells ☐ Skin Rashes

☐ Heart Disease ☐ High Blood Pressure ☐ Breathing Problems

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

____

____

____

Immunizations: (Please check all that apply)

☐ Tetanus/Diptheria ☐ Mumps ☐ Hepatitis A/B

Date: ________________ Date: ________________ Date: ________________

☐ Rubella ☐ Polio ☐ Mantoux Test - TB

Date: ________________ Date: ________________ Date: ________________

Is the applicant an active TB carrier? ☐ YES ☐ NO

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Is the applicant allergic to:

☐ Bee Stings ☐ Poison Ivy ☐ Latex

If YES, please describe reaction and treatment:

Should the applicant avoid exertion due to heart or other health concerns? ☐ YES ☐ NO

SEIZURES & CONVULSIONS:

Does the applicant have a history of seizures? ☐ YES ☐ NO

If YES, please describe a typical seizure, medication and precautions to reduce onset of seizure

MEDICATIONS:

Please list all medications, dosage, frequency and reason taken:

Please set up medications in pill boxes, or provide in labeled prescription bottles. Please supply an extra day's worth of each medication in case that medication falls on the floor. Prescription and non-prescription medication will ONLY be dispensed by a licensed nurse.

Please list any known drug allergies and resulting reation:

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COMPLETION:

- This application and waiver must be completed and signed before submission. Incomplete applications will not be processed. We believe that the information you provide in ALL sections of this application is very important to a happy and safe camp experience for your child/youth. Thank you for your cooperation.
- Please include a copy of applicant's Medical Insurance card and applicant's medications.
- Please enclose your camp deposit (payable to Cristo Vive International) with your application.

"I have completed the Cristo Vive Camp Application. The applicant has my permission to attend and participate in Cristo Vive Camp. Cristo Vive International has my authorization to use the designated Camp Physician/Nurse for emergency treatment for the applicant. Medical information may be released by the attending physician as given on this application."

Signature of Parent/Guardian X ______________________________ Date:______________

Please return this application form & deposit to:
Cristo Vive International
P.O. Box 527
Big Lake, MN 55309

Cristo Vive International
Phone: 763-263-1526 email: cvi@cristovive.net website: cristovive.net

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AUTHORIZATION FOR MEDICAL ATTENTION, MINISTRY ACTIVITY AND WAIVER FOR LIABILITY/MINORS

Authorization for emergency medical treatment for a minor child:

I,____________________________ residing at ____
(Guardian's Name) (Complete Address)

am the __________________________________ of ____
(Father/Mother/Legal Guardian) (Child's Full Name)

______ in the event all reasonable attempts to contact me at ____
(Age) (Phone Number)

or ____ have been unsuccessful, I hereby give my consent to
(Alternate Phone Number)

the Director, Cristo Vive International Ministries or designated representative to (1) obtain emergency treatment (such as X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advise of a physician and surgeon licensed in the country of participation to practice such medical care, and (2) the transfer of the minor child to any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of two other licensed physicans concur in the necessity of the surgery. I agree to release Cristo Vive International or any of it's designated representatives from all financial responsibility for any medical expense which may be incurred in the event such action needs to be taken as, I either have medical insurance or, I intend to furnish payment at my own expense.

Pertinent facts to which a physician should be alerted, IE: Allergies, Medication being taken; Physical impairments.

PERMISSION FOR MINOR CHILD TO PARTICIPATE IN THE FOLLOWING ACTIVITIES AND MINISTRY

Travel to and participate in a camp activity for persons with disability. The child will be a participant at the camp activities. As a part of this ministry, the child will be conducting physical activity in a camp facility which will include activities such as horseback riding, swimming, running, ball playing, and other typical children's activities normally conducted at summer camps. The child will also be accompanying adults on various trips and activities outside of camp site.

Waiver for Liability: I hereby affirm that I am the lawful guardian, and give my consent for the minor named above to participate in the events described in the application appcompanying this form with Cristo Vive International. I am acquainted with CVI Ministries. I will not hold this ministry liable for responsible for any injury to my child beyond the limits of my insurance that may be in force and effect, and which provides coverage for injuries such as may happen. I acknowledge that no representations have been made to me about whether such covereage does or does not exist, I understand that I am releasing Cristo Vive International, and any person officially connected with this event from any and all liability for any and all injuries, which my child may receive.

A photocopy of this authorization medical care shall be as valid as the original, and in effect until revoked in writing.

This signed release form signifies my agreement to all of the above:

Date: ____________ Signature: X ____

Printed Name of Parent/Legal Guardian: ______________________________________

Note: Cristo Vive International requires a form for each minor child to be completed and signed by the minor's parent or legal guardian before participation with any event or activity associated with CVI. No minor will be allowed to travel to or participate in any of the ministry functions without having this form completed and signed and in the possession of a designated representative of Cristo Vive International. Thank you for your cooperation.

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