



# Application

**Please print**

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

Full Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Applicant's Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

T-Shirt Size: \_\_\_\_\_

## Parent/Guardian Information

Name of Parent/Guardian: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

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

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

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

Place of Employment: \_\_\_\_\_

**How did you hear about The Baddour Center's summer program?**

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

# Emergency Contact Information

The Baddour Center will always contact parents/guardians first; however, in the event of an emergency and they cannot be reached, please provide the following information for others we may contact (grandparents, siblings, neighbor).

**Primary Contact Name:** \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

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

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

Place of Employment: \_\_\_\_\_

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

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

**Secondary Contact Name:** \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

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

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

Place of Employment: \_\_\_\_\_

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

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

**Additional Contact Name:** \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

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

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

Place of Employment: \_\_\_\_\_

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

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

**Name(s) of Siblings:**

\_\_\_\_\_

# Social/Educational Information

**Please list the name of the most recent school, training program and or residential enrollments in which the applicant is currently participating or participated in the past.**

Name of school/program: \_\_\_\_\_

Dates: \_\_\_\_\_ Reason for leaving (if applicable): \_\_\_\_\_

Describe the Applicant's favorite hobbies/forms of entertainment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Level of participation in sports/activities: \_\_\_\_\_

Assistance or guidance needed for any recreational activities: \_\_\_\_\_

Does the applicant socialize//relate well with peers: \_\_\_\_\_

Does the applicant have a history of aggression or threatening physical or verbal behavior? If so, state in your own words the nature of the behavior, possible causes, possible triggers and consequences.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any other special interests which would assist in better serving this applicant (any foods that he/she can't or won't eat; describe fitness level:

\_\_\_\_\_

\_\_\_\_\_

**Please submit your most recent psychological evaluation. It must have been completed within the last 4 years.**

# Activities of Daily Living

Please describe the applicant's level of independence in regard to each of the following activities of daily living:

<b>ADL</b>	<b>Independent circle one</b>	<b>What assistance, if any is required, please describe</b>
Eating	Yes/No	
Communicating (needs and wants)	Yes/No	
Mobility	Yes/No	
Showering/Bathing	Yes/No	
Dresses Self	Yes/No	
Bowel Management	Yes/No	
Bladder Management	Yes/No	
Oral Hygiene	Yes/No	
Follows Instructions/directions	Yes/No	
Keeps personal space neat	Yes/No	

**The Baddour Center is a tobacco and alcohol free campus and these products are prohibited on our campus.**

# Medical Information

1. Does the applicant have allergies?  Yes  No

If yes, what type (food, medicine, insect stings, hay fever, animals): \_\_\_\_\_ Please describe most recent allergic reaction: \_\_\_\_\_

2. Is the Applicant currently subject to seizures?  Yes  No

3. If the Applicant is **currently** subject to seizures, please identify:

Type of seizure: \_\_\_\_\_

How often do they occur: \_\_\_\_\_

Date of Last seizure: \_\_\_\_\_

Limitations or risks that may result from a seizure: \_\_\_\_\_

Possible triggers, causes or strategies that may be helpful to staff:

4. Does the Applicant have problems with vision?  Yes  No

5. Does the Applicant wear glasses and/or contacts?  Yes  No

6. Does the Applicant have a hearing impairment?  Yes  No

7. Does the Applicant wear a hearing aid(s):  Yes  No

If yes, please specify:  lateral  Left Ear  Right Ear

8. Has the applicant ever been hospitalized  Yes  No

If yes, reason and date of hospitalization:

9. Does the applicant have chronic/recurrent illnesses  Yes  No

If yes, what is the illness and best treatment method:

# Medications

If the applicant takes medications, bring enough medication to last the entire time of the program. Over the counter medication brought for the week must be in original containers with labels. Prescription medications must be in original containers with labels that show the applicants name and how the medication should be given.

**List all prescribed medications being taken during summer program and reasons:**

1. Name of Medication: \_\_\_\_\_

Dosage requirements/frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

2. Name of Medication: \_\_\_\_\_

Dosage requirements/frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

3. Name of Medication: \_\_\_\_\_

Dosage requirements/frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

4. Name of Medication: \_\_\_\_\_

Dosage requirements/frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

The following non-prescription medications may be stocked in the first aid supplies and are used on an as needed basis to manage illness and injury. Check those that the camper can be given:

1. Ibuprofen (Advil, Motrin)

2. Tylenol

3. Sudafed

4. Cough drops

5. Benadryl

6. Imodium

Please list any other over-the-counter medications that have proven effective in treating minor health issues or injury of the applicant:

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## ADDITIONAL APPLICANT MEDICAL HISTORY

(√) CHECK ALL THAT APPLY

- Allergies or Hay Fever
- Anemia (i.e., low iron)
- Anxiety or Panic Attacks
- Asthma
- Attention deficit/hyperactivity disorder
- Back Problems
- Balance Problems
- Bone or Joint Disease
- Bowel or Colon Disease
- Broken or Cracked Bones
- Concussion or Head Injury
- Depression
- Diabetes
- Emotional/Mental health concerns
- Fainting
- Headaches
- Heart Murmur or Heart Disease
- Hepatitis
- High Blood Pressure

- History of “faking” health issues
- Lung Problems
- Menstrual problems
- Muscle Disease or Weakness
- Neurological Disorders
  - Cerebral Palsy
  - Dystonia
- Psychiatric/psychological counseling
- Psychiatric hospitalization
- Skin Disease – Chronic
- Skin Infections – Recurrent
- Sleep Difficulties or Disorders
- Sinus Problems
- Speech Disorder
- Sprains or Dislocations
- Swallowing Difficulty
- Stroke or TIA

### IMMUNIZATION HISTORY

HAVE YOU HAD THESE SHOTS:			DATE OF LAST
Hepatitis B Series	<input type="checkbox"/> Yes	<input type="checkbox"/> No	-
Influenza	<input type="checkbox"/> Yes	<input type="checkbox"/> No	-
Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	-
PPD/TB skin test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	-

# Insurance Information

Copies of the Applicant's insurance identification cards must be provided at the time of registration. A representative of The Baddour Center will provide the Applicant's insurance information as appropriate to Health Care Providers if necessary. However, following up on any discrepancies in the filing of claims, billing, or charges is the responsibility of the Applicant's family.

List all insurances providers, policy numbers and dates of coverage:

Private Health Insurance: \_\_\_\_\_  
\_\_\_\_\_

Medicare Number: \_\_\_\_\_

If the Applicant is receiving Medicare benefits, please check all that apply:

Part A (Hospital)

Part B (Medical)

Medicaid Number: \_\_\_\_\_

State in which Medicaid is received: \_\_\_\_\_

Prescription Drug Plan: \_\_\_\_\_



## Physical Evaluation

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ BP: \_\_\_\_\_

Allergies (food or drug): \_\_\_\_\_

\_\_\_\_\_

History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

General Appearance:

Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_

Nose: \_\_\_\_\_ Skin: \_\_\_\_\_

Mouth: \_\_\_\_\_ Neck: \_\_\_\_\_

Chest: \_\_\_\_\_ Breasts: \_\_\_\_\_

Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Primary diagnosis: \_\_\_\_\_

Description of specific physical impairments, physical limitations or orthopedic impairments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Evaluation Page 2

List current medications: \_\_\_\_\_

\_\_\_\_\_

Impressions and recommendations: \_\_\_\_\_

\_\_\_\_\_

The following screening is required prior to attending the summer program. Give date and results.

PPD: \_\_\_\_\_

Physician's Name (Please Print or Stamp)

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

\_\_\_\_\_  
Address

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

\_\_\_\_\_  
Phone Number

# Consent and Agreement Form

**Medical Care, Medications and Procedures:** I/We give permission for licensed nursing personnel to administer prescribed and over-the-counter medications and procedures consistent with the licensure of such nursing personnel as required and as reviewed by physician's orders, including but not limited to the treatment of the common cold, sinus infection, constipation, headache, etc.

Applicant's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

**Photographic Release:** I/We hereby give our consent to Y.O.U.R. Summer Program to photograph and/or make video or audio recordings of the above named applicant without limitation and to use such photographs, videotapes or audiotapes and the applicant's name, likeness, and voice and related stories in connection with any of the work, programs, projects, fundraising or other endeavors of Y.O.U.R. Summer Program in any and all media, including electronic or digital.

Applicant's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

**Personal Property:** I/We recognize that Y.O.U.R. Summer Program does not accept any responsibility for the care and safekeeping of the clothing and other personal property of the above name applicant. I understand that any items the applicant brings to the program (including, but not limited to cameras, cell phones or expensive clothing) are the responsibility of the applicant.

Applicant's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

**Swimming Consent:** I/We hereby request that my applicant be allowed to participate in swimming and other water activities offered to the participants in the summer program. **I/We have been informed and understand should the applicant have an active seizure disorder, The Baddour Center reserves the right to restrict/deny access to swimming. Baddour also reserves the right to deny access to swimming and any water activities if determined the safety of the applicant or the safety of other participants/staff could be compromised.**

Applicant's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Please attach a recent photograph