



Thank you for your interest in Camp Sonshine. Please fill out the following application and return it as soon as possible to:

Camp Sonshine
c/o Camp Manatawny
33 Camp Road
Douglassville, PA 19518

OR FAX TO 610-689-0174

Feel free to contact us with any further questions or comments.
610-689-0173



CAMPER INFORMATION

NAME (LAST, FIRST): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FEMALE MALE AGE: _____ DATE OF BIRTH: _____/_____/_____

T-SHIRT SIZE: YOUTH (S,M,L) _____ ADULT (S,M,L,XL) _____

OFFICIAL DIAGNOSIS: _____

LEVEL OF DISORDER: MILD MODERATE SEVERE PROFOUND

LIST SPECIAL EQUIPMENT USED: _____

PARENT/ GUARDIAN INFORMATION

NAME(S): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE # (HOME): _____ (WORK/ CELL): _____

EMERGENCY CONTACT INFORMATION FOR EVENT

NAME: _____

RELATIONSHIP TO CAMPER: _____

PHONE # (HOME): _____ (WORK/ CELL): _____

NAME: _____

RELATIONSHIP TO CAMPER: _____

PHONE # (HOME): _____ (WORK/ CELL): _____

CAMPER NAME: _____

PLEASE CHECK ALL THAT APPLY

MOBILITY

- WALKS INDEPENDENTLY
- NEEDS ASSIST DEVICE: _____

TOILETING

- INDEPENDENT
- NEEDS ASSISTANCE
- NEEDS TO BE REMINDED

MEAL TIME

- INDEPENDENT
 - NEEDS ASSISTANCE
 - FOOD PREFERENCES: _____
 - FOOD ALLERGIES: _____
 - OTHER RESTRICTIONS: _____
-

COMMUNICATION

- COMMUNICATES WELL
 - LIMITED VERBAL COMMUNICATION
 - USES PICTURE BOARD / SIGN LANGUAGE: _____
-

- SPECIAL NOTES: _____
-

ACTIVITY LIMITATIONS

- RUNNING
 - HORSES
 - WATER ACTIVITIES
 - OTHER: _____
-

CAMPER NAME: _____

PLEASE ANSWER THE FOLLOWING

WILL THE CAMPER BE STAYNG OVERNIGHT? YES NO

IF YES, WILL A PARENT ALSO STAY OVERNIGHT? YES NO

IS THERE ANY INFORMATION WE NEED TO MAKE THE CAMPER
COMFORTABLE OVERNIGHT (BEDTIME ROUTINE, FAVORITE TOYS)?

HOW DOES THE CAMPER REACT TO NEW PEOPLE/PLACES? _____

HOW DOES THE CAMPER LIKE TO PLAY? IN A GROUP ALONE

LIST FAVORITE RECREATIONAL ACTIVITIES: _____

HOW DOES THE CAMPER REACT TO LOUD NOISES? _____

ADDITIONAL INFORMATION THAT WILL HELP US BETTER UNDERSTAND
THE CAMPER AND ENSURE HE/SHE HAS A GREAT TIME AT CAMP: _____

CHALLENGING BEHAVIORS THAT OUR STAFF MIGHT ENCOUNTER - PLEASE
BE SPECIFIC ABOUT BEHAVIOR AND TRIGGERS (BITING, PINCHING, ETC.):

METHOD OF DISCIPLINE AT HOME:

CAMPER NAME: _____

MEDICAL INFORMATION

YEAR OF LAST TETANUS SHOT? _____

HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY)

- | | |
|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> NOSE BLEEDS |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> STOMACH UPSETS |
| <input type="checkbox"/> POOR HEAT TOLERANCE | <input type="checkbox"/> EAR TROUBLE |

HOW ARE THESE SYMPTOMS TREATED, IF SIGNIFICANT? _____

DOES THE CAMPER HAVE ANY ALLERGIES? _____

DOES THE CAMPER SUFFER FROM SEIZURES? YES NO

DATE OF LAST SEIZURE: _____ FREQUENCY: _____

LENGTH: _____ SEVERITY: _____

SPECIAL INSTRUCTIONS: _____

ANY OTHER HEALTH/MEDICAL ISSUES OR CONCERNS? _____

DOES THE CAMPER RECEIVE ANY MEDICATION? YES NO

PLEASE LIST MEDICATIONS* AND DOSING SCHEDULE:

***PLEASE BRING ALL MEDICATIONS IN THE ORIGINAL PRESCRIPTION
CONTAINER TO THE NURSE UPON ARRIVAL**

CAMPER NAME: _____

INSURANCE INFORMATION

INSURANCE CO. NAME: _____

IDENTIFICATION #: _____

POLICY HOLDER: _____

RELATIONSHIP TO CAMPER: _____

PRIMARY CARE PHYSICIAN: _____

CONSENTS:

TO THE BEST OF MY KNOWLEDGE, THE HEALTH INFORMATION GIVEN ABOVE IS CORRECT. I UNDERSTAND THAT I WILL BE NOTIFIED IF A SERIOUS INJURY OR ILLNESS OCCURS. HOWEVER, IF I AM UNABLE TO BE REACHED, I DO GIVE MY PERMISSION TO THE CAMP SONSHINE MEDICAL STAFF TO SECURE PROPER MEDICAL TREATMENT FOR MY CHILD.

I GRANT PERMISSION FOR MY CHILD'S PICTURE TO BE USED ANONYMOUSLY IN CAMP PROMOTIONAL MATERIALS. Yes _____ No _____

PARENT/GUARDIAN SIGNATURE

DATE