



Shepherds Camp Summer 2024

1 WEEK, 2 WEEK & 1:1 SESSIONS

Est. 1962



Serving individuals with
developmental disabilities
since 1962.

SHEPHERDS CAMP AT ARROWHEAD
122 Arrowhead Cottage Road, Brackney PA
www.shepherdscamp.org | 570.663.2419

Shepherds Camp Summer 2024

We are excited to see you this summer! Check out this important information.

Dear Campers, Parents, and Care Providers,

Guess what? It's almost summer again!! We have been having lots of fun with our fall and winter indoor activities the past few months, but I am SO excited to get back outside in the warm weather with you to go on boat rides, drive the pedal carts, and hang out on the swings! We also now have an awesome new wheelchair accessible balcony in the gym for campers to hang out on during the rainy summer days!

Summer 2024 registration is now OPEN for campers to sign up! Please remember to read the following instructions regarding the registration process.

SCHOLARSHIPS: We are excited to offer scholarships to our campers and invite you to apply. Contact us to request an application.

SECURING YOUR SESSION: In order to secure your spot we need the following 3 things: a completed registration form, a \$100 deposit, and a copy of an updated physical (or date of the scheduled physical, written at the bottom of page 2 of the forms).

CONFIRMATION: Once we have received all of the required items, a confirmation form will be sent with the session dates your camper is registered to attend. Please read through the information on the form to make sure it is accurate. Then, complete and return the enclosed medical forms.

IDENTIFYING CAMPER CLOTHING: Please remember to write your camper's full name or initials on the tag of each clothing item. We want to ensure that all camper clothing is sent home at checkout.

I can't wait to see all my friends back at camp this summer! It's going to be a great one!

Blessings,



Summer James
Program Manager

CAN'T WAIT TIL SUMMER?
SPRING SESSIONS!

Choose from 14 spring weeks of camp. Hurry, spring sessions are filling up quick!



Shepherds Camp 2024 Summer Registration Form

***Registration form, physical within 1 year of camp date, and \$100 deposit are required to reserve a space.

Camper _____ Age _____ M F DOB ___/___/___
Address _____ Phone () _____ - _____
City _____ State _____ Zip _____ County _____
Adult T- Shirt Size: (Circle One) 3XL XXL XL L M S Nickname _____
Has the camper attended Arrowhead before? Yes No Last year attended: 2023 _____

Care Provider _____
Home Phone () _____ - _____ Cell Phone () _____ - _____
Address _____ City _____ State _____ Zip _____
Care Provider E-mail address _____
Relationship to Camper: (FCP, parent, sibling, House Manager, etc.) _____
Camper receives services from (name of agency): _____
My camper is an OPWDD individual (**required - please circle one**): YES / NO

Please Check Program(s) Desired:

1 Week Programs **\$800 / person**
(Check-out 10 AM)

- Sunday, May 26th - Friday, May 31st
- Sunday, June 1st - Friday, June 7th

Registration Fee: \$100.00 (non-refundable)
Remaining Balance: \$700.00 **Due: May 11th**

2 Week Programs **\$1,600 / person**
(Check-out 10 AM)

- Sunday, May 26th - Friday, June 7th
- Sunday, June 23th - Friday, July 5th
- Sunday, July 21st - Friday, August 2nd

Registration Fee: \$100.00 (non-refundable)
Remaining Balance: \$1,500.00 **Due: May 11th**

1:1 Programs

[open to campers who require individual care]

\$1,850 / person
Check-in 10AM,
Check-out 1:30PM

- Monday, May 20th - Friday, May 24th
- Monday, June 10th - Friday, June 14th
- Monday, June 17th - Friday, June 21st
- Monday, July 15th - Friday, July 19th
- Monday, August 5th - Friday, August 9th

Registration Fee: \$100.00 (non-refundable) Remaining Balance: \$1,750.00 **Due: May 11th**

Please contact the main office today for information on Camper Scholarships!

Make check or money order payable to: Arrowhead Bible Camp

Mail to: Shepherds Camp, Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812

Questions? Call - (570) 663-2419 Fax- (570) 663-2903 bkarrowhead@gmail.com www.shepherds-camp.org

Office Use Only

Rec'd: _____ M1: ___ M2: ___ PRN: ___ MA: ___ Amount: _____ Check # : _____ E: ___ C: ___

NOTE: While this camper may have attended camp in the past, his/her counselor for the session may be new to them. Please complete the following information thoroughly to assist us in caring for your individual's unique needs.

Activities of Daily Living:	Independent	Assistance	Total Care	Please specify assistance required
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Using Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Washing Hands and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying Shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstruation (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Camper uses: Glasses Hearing Aids Dentures Orthopedic Device (explain in Mobility) Other: _____

Toileting & Overnight Care:
 Camper requests to stay in: Cabin Dorm
(if requesting a dorm, camper must be able to use stairs)
 Bunk with: _____
 Do NOT bunk with: _____
 Needs Bedrails
 Uses CPAP/Oxygen Concentrator
 Wets Bed: Never Occasionally Frequently
 How is bed-wetting handled? _____
 Wears Diapers: Never Nightly Daily Always
 Uses Commode/Portable Urinal at Night
 Sleeps through the night
 Needs to be awakened to use the toilet
 Hourly bed checks
 Bowel Routine: _____
 Other: _____

Mobility:
 Walking: Normal Slow Unsteady No Walking
 Cane(s) Walker No Stairs Prone to Wander
 Wheelchair: Electric Manual Always Distance
 Braces/Orthopedic Device: (Explain) _____
 Transfer Assistance: Independent 1-Person Assist
 2-Person Assist Hoyer Lift
 Other: _____

Communication:
 Verbal Speech Impaired Speech No Speech
 Sign Language Communication Device/Book
 Normal Hearing Hearing Impaired Deaf
 Normal Sight Vision Impaired Legally Blind
 Other: _____

Behavior:
 Active Sedentary Excitable Passive Behaves Rebellious Participates Cooperative Stubborn
 Quiet Loud In need of constant watching Independent Attention-Seeking Story-Teller
 Follows Directions: circle Yes / No Needs Time to Process Needs Reminders/Cues Needs Physical Assistance
 History of Aggression: circle Yes / No Verbal Physical against Peers/Staff Self-Injurious Other
Note: For the safety of all campers and staff, individuals who exhibit extreme aggressive behavior will need to undergo a screening process before accepted into the camp program.
 Exhibits extreme aggressive behavior: circle Yes/ No
If this camper has a behavior support plan, please provide a copy for camp staff.
 What provokes or precedes the aggressive behavior? _____
 What interventions correct the aggressive behavior? _____
 Describe any fears the camper may have: _____
 Describe the camper's personality on a typical day: _____
 What assistance/prompts do you commonly give the camper: _____
 History of inappropriate behavior to the opposite gender: _____
 How does this camper act when upset or angry? _____
 Other: _____

Physical / Medical Information:
 Please enclose completed medical and physical form with the Application/Registration Form. Please note that completed medical and physical forms are needed in order to complete the registration process.
NOTE: If you are unable to do so please state why and give **date that the physical is scheduled.**
 Reason: _____ Date Scheduled: _____

Eating:

- Eats Independently Needs Assistance Eating Feeding Tube: _____
- Whole Diet 1" Pieces ½" Pieces ¼" Pieces Ground Puree Meat Cut *Only*
- Liquids: Thin Nectar Honey Pudding
- Overeats PICA Uses Straw for Liquids No Straws May Take Food from Others Needs Verbal Prompts
- Specialized Adaptive Equipment (**must be brought along with camper**): _____
- Food Restrictions: _____
- Other: _____

YES / NO (REQUIRED - CIRCLE ONE) OPWDD Food Modifications:

Camper is an OPWDD Individual and their diet must conform to the OPWDD Food Regulations.

If Yes, Describe: _____

If Yes, Eating Strategies: _____

Swimming: *Note: A Lifeguard is on duty at all times*

- Enjoys Water Fears Water
- Swims Independently No Swimming
- Needs 1:1 Supervision in Water
- Boats (Accompanied by Staff & Wearing Life Jacket at all times)
- Shallow End Swimming (0-4 feet deep)
- Deep End Swimming (over 6 feet deep)
- Must wear life jacket in shallow end
- Must wear life jacket in deep end

Other: _____

Program Information:

Favorite Activities: _____

Goals/Objectives being worked on: _____

Favorite Song: _____

Favorite Food: _____

Favorite Chore/Job: _____

Dislikes: _____

 Attends School: Grade & School _____ Employed: Type & Location _____

Other: _____

Health:

Allergies: _____

- Obesity Diabetes Asthma Blood Clotting Disorder Seizures Frequent UTI Frequent Constipation
- Frequent Diarrhea Recent Illness/Injury/Hospitalization: _____
- Allergy to Bee Stings or Insect Bites? Describe Reaction & Treatment: _____

Does this camper sunburn easily? Yes No If Yes, list restrictions: _____

Should this camper avoid exertion due to heart or other health concerns? _____

Describe additional health concerns that may hinder this camper's participation: _____

Other: _____

Activity Restrictions:

Please review the following camp activities and determine whether this camper has permission to participate. Contact the camp office with any questions. All activities are closely supervised and modified to fit the camper's individual ability level. Check 'yes' if camper is allowed to participate in activity, check 'no' if camper is restricted from activity.

- | | | | |
|-------------------|--|--------------|--|
| Adaptive Archery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Basketball | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Volleyball | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nature Walks | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kickball | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fishing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Ride (No Hay) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mini Golf | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bocce Ball | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pedal Carts | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9 Square | <input type="checkbox"/> Yes <input type="checkbox"/> No |

CONTACT INFORMATION- Campers will not be admitted without completed emergency contact
ALL INFORMATION BELOW NEEDS TO BE UPDATED AND RELEVANT AT CHECK-IN
Emergency Contact Person - 24-hour coverage - Person other than primary care provider who will be contacted
in the event that the camper needs to be picked up early from camp:

Name: _____ Relationship to Camper: _____ Phone: (____) ____ - _____

Other names/numbers: _____

Is the primary care provider planning to be away during the camp sessions?

- No, the primary care provider will be the contact person during the camp session.
- Yes, and the PCP has informed the 24-hour contact person listed above that they will be on call and responsible.

13. Permission/Medical Release/Authorization for Treatment (The following must be signed by custodial parent/guardian, care provider, or camper if self-guardian)

A. I, as an individual, parent, guardian, or appointed representative of the individual, understand that Arrowhead Ministries, Inc., henceforth referred to as "AMI", takes reasonable efforts to operate and conduct activities in a safe and responsible manner. These recreational activities include but are not limited to those named in this registration packet. I understand that these activities and the actions or inactions of other program individuals involve certain inherent risks. I recognize these risks and agree to assume all liability for these risks by allowing the individual to attend AMI's camp and participate in such programs and activities. I hereby release, indemnify, and hold harmless AMI, its officers, agents, employees, and all others from all liability and damages for injury, illness, and or death sustained by the individual relating to or deriving in any way from participation in aforementioned programs and activities, whether arising from an act of omission to the fullest extent permitted by law.

B. I, as an individual, parent, guardian, or appointed representative of the individual, understand AMI generally provides supervision of the individual in a 5:1 individual to staff ratio for all programs and activities, unless 1:1 is specified.

C. I, as an individual, parent, guardian, or appointed representative of the individual, hereby certify that I will accept emergency care offered by AMI for injury or illness. I hereby acknowledge that the designated first aid person/hospital in charge may perform emergency care and I hereby grant permission to AMI to release any medical information required by said parties and do hereby give permission for treatment. I understand that medical care will be provided according to the standard set forth by the Commonwealth of Pennsylvania and said designated first aid person is protected under the Good Samaritan Act. I acknowledge that all medications will be administered by AMI's nurse and hereby consent to treatment for minor illnesses as deemed necessary. I hereby give my permission to the medical personnel selected by the camp staff to order x-rays, routine tests, treatment, and necessary transportation for the above named individual. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp staff to secure and administer treatment, including hospitalization, for the individual as named above.

E. I attest to the fact that the above named individual is free of any communicable disease prior to attending camp, or I have spoken with the Camp Nurse and Program Manager to ensure safety.

F. I, as an individual, parent, guardian, or appointed representative of the individual, hereby grant AMI permission to use any narratives, film, photographs, videotape, sound, and digital recording of any kind made by AMI of the aforementioned individual for the promotion of its programs and services in any publication or media outlet including website entries, without payment or any other consideration. I understand and agree that these materials will become the sole and exclusive property of AMI. I irrevocably authorize AMI and its agents to edit, alter, copy, exhibit, publish, distribute, or otherwise use any of aforementioned individual's likeness derived above for the purposes of publicizing Arrowhead's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product including written or electronic copy, wherein the individual's likeness appears. Additionally, I waive my right to royalties or other compensation arising or related to the use of any likeness. I hereby hold harmless and release and forever discharge AMI from all claims, demands, and causes of action which I, the aforementioned individual, heirs, representatives, executors, administrators, or any other persons acting on the individual's behalf or on the behalf of the individual's estate have or may have by reason of authorization.

By checking this box and signing below, I agree to have read and understood all information on this form and have completed all forms to their fullest.

Care Provider Signature: _____ **Print name:** _____

Date: _____

After review of the preceding information, the camp program manager will make a decision regarding acceptance into the camp program. **All necessary paperwork must be completed, signed, and submitted by May 13th.** If the camper is accepted, you will receive a confirmation letter, medicine administration form, and list of what to bring to camp. The primary care provider will be contacted if the camp program manager has any concerns regarding acceptance. The registration fee will be refunded if the camper is denied acceptance to the program.



2024 MEDICAL INFORMATION CARE PROVIDER'S FORM

Camper _____ Age _____ M F DOB ___/___/___
Phone () _____ - _____

Parent/ Guardian / Care Provider Name(s) _____
Insurance _____ Policy # _____

Your Medicare/Medicaid coverage or personal/family insurance would apply to all claims while at camp. However, the camp does provide Excess Medical Expense coverage.

Physician's Name _____ Phone () _____ - _____
Preferred Hospital for Emergency Treatment _____

Medical History (Diagnosis List):

Diabetes: Yes, camper has Diabetes Mellitus No, camper does not have Diabetes Mellitus
If Yes: Frequency of Glucose Checks _____ Insulin Shots Diet Management Medication Management

Communicable Diseases: Hep A Hep B Hep C HIV Not Applicable | Explain: _____

COVID-19 History:

Yes, camper has had COVID-19, if yes when: _____ No, camper has not had COVID-19
 Yes, camper has been vaccinated for COVID-19 Please provide a copy of proof of vaccination.

Symptoms: Please check which problem areas experienced frequently by the camper and how you treat these at home. (Example: Diarrhea give Pepto Bismol)

Table with 2 columns: Symptom, Remedies. Rows include Nausea, Diarrhea, Stomach-aches, Headaches, Constipation.

Allergies
 No Known Allergies
 Known Allergies: _____

Medication:

Yes, the camper is regularly on medication. Please contact your camper's doctor regarding any meds, ointments, etc. that could be put on hold while at camp. A medication administration form will be sent with the confirmation letter which must be completed and submitted to camp in advance of your camp session.

Seizures: Yes, camper experiences seizures (see below) No, camper does not experience seizures

Please inform us on the following:

- Date of last seizure _____
- Frequency of seizures _____ / week or _____ / month
- Call 9-1-1 after seizures lasting _____ minutes
- Seizure presentation (what does a typical seizure look like) _____

Care Provider's Signature _____ Date _____



2024 MEDICAL INFORMATION
ATTENDING PHYSICIAN'S FORM

Camper's Name _____
Physician's Name _____ Phone () _____ - _____
Address _____ State _____ Zip _____
Hospital associated with: _____

A current (**within 1 year of camp date**) health physical *may* be attached. *Reverse side **must** be completed by Care Provider.

General Physical Condition

Height _____ Weight _____ BP _____ Eyes _____ Ears _____ Lungs _____

Hypertension Hypotension Tachycardia Bradycardia Constipation

Date of last Tetanus shot _____ Is this camper subject to seizures? No Yes

Should the camper be restricted from any camp activities? No Yes, _____

Medication

Indicate the following:

No prescription medication Total support in receiving medication
 Independent / Self-Medicating

Mental Evaluation

Diagnosis: _____

Further Comments: _____

Physician's Signature

Date