CAMP 4:13 2024 GENERAL INFORMATION keep this page
July 29 – August 2
Dear Applicant/Legal Guardian:

Please use the following checklist to complete your application.

- ✈ Have you read the entire application?
- ✈ Have you completed the application and attached any additional information you consider pertinent?
- ✈ Have you included the required $100 non-refundable deposit, or full payment of $325? Any balance is due upon arrival. Only send exact tuition amounts please.
- ✈ Have you included a copy of your Medical Assistance and/or Medicare card?
- ✈ Have you included all the application pages together? GUARDIAN AND PHYSICIAN SIGNATURES MUST BE ORIGINALS. Incomplete applications cannot be processed.

- ✈ Has your physician completed and signed the Medical Form of the application? ALL APPLICANTS MUST HAVE A MEDICAL EXAMINATION within twelve months prior to the date of CAMP 4:13. Each applicant must present a current HEALTH history as part of this application. Substitutions of this form will not be accepted; however additional information is appreciated. All medications must be in original prescription bottles clearly marked for content, dosage, and frequency. All medical and behavioral incidents will be documented. Applicants over 50 lbs, needing transfers **should expect to be lifted with the help of mechanical assistance which you must provide**. Behavioral, food, etc. charting will not be done. Only medication charting will be recorded. Camp 4:13 programming takes precedence over any individual planned programming.

APPLICANTS UNDER THE AGE OF 10 must be accompanied by a parent/guardian. A spouse or parent/guardian providing applicant's care may accompany him/her at no charge.

If you are PROVIDING YOUR OWN CAREGIVER, their completed staff application must be submitted with yours.

ACCEPTANCE to Camp 4:13 is not guaranteed. We reserve the right to refuse acceptance of applicant based on our ability to provide adequate care in conjunction with applicants needs with regard to our programming. Pre-registration is required. An acceptance letter will be mailed two weeks prior to the date of Camp. If applicant is not accepted, a full refund will be given.

REGISTRATION begins on Monday, July 29th at 1:00pm and ends at 2:00pm.
Camp concludes at 1:00 pm on Friday, August 2nd.
Be sure your transportation is punctual.

CAMP ADDRESS: Mountain Valley Retreat Center, 1366 N Hwy 7, Hot Springs, AR 71909.

TRANSPORTATION to and from the grounds is the applicant's responsibility.

For office use only

Date Received: _____

Fee Received: $ _____

Camper Application 2024 Camp 4:13

at Mountain Valley Retreat Center, 1366 N Hwy 7, Hot Springs, AR 71909

Incomplete applications cannot be processed and will be returned.

MAIL COMPLETED APPLICATION WITH GUARDIAN SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:

ARKANSAS DISTRICT A/G CAMP 4:13; 10924 INTERSTATE 30; Little Rock, AR 72209

For more information email: pam@dagchurch.com or call 479-549-7070

Cost: $325.00

A NON REFUNDABLE $100 DEPOSIT MUST BE INCLUDED- make check payable to Arkansas District A/G & NOTATE "CAMP 4:13"

NO APPLICATIONS CAN BE ACCEPTED AFTER JULY 15TH.

Applicant Name _____ Preferred Name _____
(if different from first name)

Applicant's Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Date of Birth_____/_____/_____ Email _____

Age ____ (Applicant must be over 10 or a parent must attend as caregiver staff)

T-shirt size: _____

☐ Foster Home ☐ Institution ☐ Live in own home/apt ☐ Live with parent/guardian

☐ Residential Facility/Group Home Name_____

☐ I am my own Guardian **If not, Name of Legal Guardian** _____

Relationship_____ Email _____

Address _____

City _____ State _____ Zip _____

Phone Day (_____) _____ Evening (_____)_____

Emergency number different than guardian:

Name _____ Relationship to applicant _____

Phone (____) _____

Home Church _____ City _____

Phone (_____) _____ Email _____

FILL OUT PART 1 IF APPLICANT HAS PHYSICAL DISABILITY.
FILL OUT PART 2 IF APPLICANT HAS INTELLECTUAL DISABILITY.
IF APPLICANT HAS BOTH DISABILITIES FILL OUT PART 1 & PART 2

PART 1: Applicant has a physical disability

DIAGNOSIS

☐Brain Trauma ☐Multiple Sclerosis ☐Spina Bifida

OTHER FACTORS

☐Cerebral Palsy ☐Muscular Dystrophy ☐Spinal Cord Injury
☐Uses Sign Language ☐Non-Verbal ☐Deaf
☐Hearing-Impaired ☐Uses Hearing Aides ☐Blind
☐Sight Impaired ☐Will Bring Service Dog ☐Cannot climb stairs
☐Other-explain: _____

SELF HELP AND SUPERVISION NEEDED

☐Lives Independently - No assistance needed
☐Will require assistance from Camp 4:13 Staff
☐Minimal ☐Moderate ☐Individual
☐Will provide own caregiver* ☐Male** ☐Female**
Fill in information for caregiver the applicant is providing
Name* ** _____
City _____State _____ Zip _____
Caregiver's completed Staff Application must be submitted with this application.
****Unless related, caregiver must be of same sex as applicant.***

PART 2: Applicant has an intellectual disability

INTELLECTUAL ABILITY

☐High Functioning ☐Mild ☐Moderate ☐Severe/Profound*
** Current programs are not designed for people with Severe/Profound intellectual disabilities*

OTHER FACTORS

☐Non-Verbal ☐Uses Sign Language ☐Hearing Impaired ☐Deaf
☐Uses Hearing Aides ☐Down's Syndrome ☐Sight Impaired ☐Blind
☐Cannot Climb Stairs
☐Autistic Behavior - describe: _____

SELF HELP AND SUPERVISION NEEDED

☐Lives Independently
☐Needs minimal supervision
☐Requires individual staff supervision due to
☐Intellectual disability ☐Wheelchair Manipulation
☐Poor Behavior - explain: _____
☐Will provide own caregiver* ☐Male** ☐Female**
Fill in information for caregiver the applicant is providing
Name* ** _____
City _____State _____ Zip _____
Caregiver's completed Staff Application must be submitted with this application.
****Unless related, caregiver must be of same sex as applicant.***

Please check the most appropriate statements in each category

SKILL EVALUATION

MOBILITY

☐Walks Alone
☐Slow ☐Medium ☐Fast
☐Needs assistance
☐Cannot walk
☐Walks Uses and will bring
☐Walker ☐Braces ☐Crutches
☐Electric Wheelchair ☐Manual Wheelchair
☐Can manipulate wheelchair alone ☐Cannot manipulate wheelchair alone
☐Paraplegic ☐Quadriplegic
☐Bears own weight ☐Transfers Alone
☐Use Hoyer Lift. (Guests unable to transfer alone will be lifted with mechanical help. **YOU MUST BRING YOUR OWN EQUIPMENT**.)

SKILL EVALUATION *continued*

EATING

☐Independent - needs no assistance
☐Needs assistance with_____
☐Dependent, must be fed (Please provide a week's supply of disposable bibs & straws if needed)
☐Has difficulty swallowing ☐solids ☐liquids ☐must use straw (Please send supply for week)
Appetite ☐large ☐medium ☐small ☐limit helpings

Allergic to foods listed: _____
Diet restriction that CANNOT lapse during camp: _____

(We are unable to provide specialized charting or diet for each applicant due to a camp type environment. If you cannot be tolerant in this area, YOU must provide special dietary foods i.e.: sugar free food and drink. Refrigeration and special preparation of food is NOT available.)

COMMUNICATION

☐No Difficulty
☐Has difficulty
☐expressing self
☐ Understands directions and prompts
☐Slow to communicate needs
☐Difficulty understanding directions
☐Uses gestures
☐Non-verbal Uses sign language (Please attach a description of signs)
☐Uses own language board (Please send with applicant)
Comments _____

BEHAVIOR

☐Generally happy (check all that apply) ☐Compliant ☐Social ☐Helpful ☐Cooperative
☐Generally unhappy (check all that apply) ☐Noncompliant ☐Withdrawn ☐Prone to depression
☐Does well in large groups ☐Does NOT do well in large groups
☐Cautious/Shy ☐Wanders (Note: applicant who wanders off may be sent home for safety)
☐Physically Abusive/Aggressive ☐to self ☐to others ☐to staff
Adapts to new environment ☐Quickly ☐Slowly
☐Autistic Behavior - describe: _____
Other behaviors - Explain _____
Are there any behavior problems you handle in specific ways and would like us to continue?
_____
We ask this because we will try to be consistent with expectations and discipline at home. Verbal instructions are inadequate.

SELF CARE & DRESSING

☐Independent - needs no assistance
☐ Assistance is needed because applicant is: ☐slow ☐needs prompts
☐Cannot dress self without assistance Please explain: _____
☐Totally dependent
☐Needs help with personal hygiene Describe assistance needed: _____
Usual bedtime _____ Usually awakens at _____
Special Sleeping Habits _____
☐Written instructions for specific care needs are listed on a separate page.

TOILET NEEDS - Send adequate for needs.

You MUST bring your own shower/toilet chair if needed

☐Independent - needs no assistance
☐Needs assistance with_____
☐Totally Dependent ☐Catheter ☐Colostomy
☐Uses Depends/Diapers ☐at all times ☐only at night (Bring enough for the entire week)
☐Incontinent: ☐Bowel ☐Bladder (Depends will be used)
☐Wets Bed (Supply adequate bedding, clothing, and/or Depends as laundry is not done during camp)
Female guest is able to care for self during menstruation:
☐Fully ☐Partially ☐Not at all ☐Expected during week

ACTIVITIES

☐Independent - needs no assistance
☐Needs assistance in some activities: ☐Arts/Crafts ☐Sporting/Recreation
☐Dependent for all activities
Water Sports: ☐ Not allowed ☐Swims shallow ☐ Swims deep
☐Uses flotation ☐Does not swim ☐Afraid of water
Activities applicant enjoys _____

Recreational activity applicant cannot participate in: _____

Camp 4:13 Camper APPLICATION RELEASE FORM

I give permission as legal guardian for the applicant to attend Camp 4:13. To the best of my knowledge, all signatures and information in the Application is correct and the person herein described has my permission to engage in all activities, except as noted by myself and/or physician. I further understand that the Arkansas District Camp reserves the right to reject any applicant whose needs cannot be met by staff.

I understand that due to specific state laws and Arkansas District Camp policy, ALL medications, whether prescription or non-prescription, brought to Camp MUST be in original container/prescription bottle, clearly marked with the name, dosage, frequency, times, and prescribing physician and not in pre-poured containers except for those pre-poured from a pharmacy if medication, prescribing physician and pharmacy are identified. Applicant will not be allowed to stay if this is not followed.

In the event I cannot be reached in an EMERGENCY, I give permission to the Health Care Professional selected by the Arkansas District Camp staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery. I will assume financial responsibility for any medical treatment not covered by Arkansas District insurance.

If applicant displays inappropriate behavior, which causes dismissal, the legal guardian, or current home assumes immediate responsibility for transportation and its cost to return applicant home. No refunds will be given.

I agree not to send applicant if exposed to a contagious disease within three weeks of the event, and I will notify Arkansas District Camp if applicant must cancel. No one will be denied attendance at Camp because of religion, creed, national origin, sex, age, or disability.

I release and hold harmless Arkansas District Camp, its board of directors, staff, leadership, and volunteers, from liability due to negligence by Arkansas District staff or volunteers. I shall bring no claims, demands, or litigation against Arkansas District Camp for losses due to bodily injury, death, or property damage arising out of or related to participation at Camp 4:13.

I understand that individuals are prohibited from carrying any weapon, as defined by state and local law, and including, but not limited to; handguns, firearms, “electric weapons” identified as any device which is used or intended to be used to immobilize or incapacitate persons by the use of electric current, a knife, a Billy club, or any other implement that is fashioned, designed, or intended to be used as a weapon, at any Arkansas District Camp events. I also realize that tobacco, alcohol and drugs (except those administered by Medical Staff) are not allowed at Camp 4:13.

Permission is given to Arkansas District Camp to use photographs (individual or group) and/or multi-media images and recordings made or obtained.

The information contained in this application is correct, to the best of my knowledge. I have read, understand, and agree to the above statement and agree with the aforementioned terms and conditions subject to attending an Arkansas District Camp 4:13.

Parent/ Legal Guardian Name:_____Contact Phone: _____

Signature of Legal Guardian_____ Date _____

Or Applicant Signature if own legal guardian

(Applications cannot be processed without proper signatures)

A CONFIRMATION OF ACCEPTANCE WILL BE SENT TWO WEEKS PRIOR TO CAMP

Required form-page 5

2024 MEDICAL FORM No substitutions of this form will be accepted All applicants must have a medical examination within twelve months prior to date of camp applying for.

PLEASE PRINT

Medical History for (Applicant's name) _____Height_____ Weight _____

Blood Pressure _____Medical diagnosis of disability: _____

Explanation/Onset/Cause of disability: _____

Applicant's current health condition: _____

Operations/Serious Illness—Dates & Description: _____

Chronic/Recurring Illness: _____

Applicant has seizures:
☐No ☐Yes - Frequency _____ Date of last seizure _____ Controlled by medication: ☐No ☐Yes

Describe seizure _____

Activities applicant should not participate in _____

ALLERGIES

☐Penicillin ☐Aspirin ☐Latex ☐Hay Fever
☐Food Allergy: _____☐Other: _____

DISEASES/PAST ILLNESS

☐Diabetes ☐Asthma ☐Chicken Pox ☐Tuberculosis ☐Other: _____

IMMUNIZATIONS

Up to date: ☐ yes ☐ no

☐Tetanus Date_____ ☐HBV Date 1_____ Date 2_____Date 3_____

For Applicants 18 Years & Under Enter month & year of each immunization

☐DPT/DT/TD Date 1_____ Date 2_____ Date 3_____ Date 4_____ Date 5_____
☐POLIO Date 1_____ Date 2_____ Date 3_____ Date 4_____ Date 5_____
☐MMR Date 1_____ Date 2_____ Date 3_____ Date 4_____ Date 5_____
☐HBV Date 1_____ Date 2_____ Date 3_____ Date 4_____ Date 5_____

MEDICATION: ALL MEDICATIONS MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE MARKED FOR CONTENT, DOSAGE, AND FREQUENCY

MEDICATION NAME	DOSAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Adverse reactions from medications: _____

PHYSICIAN PERMISSION

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in Camp 4:13 functions through the end of the calendar year, except as noted above.

Physician's Name _____

Physician's Signature_____ Date _____
RN, LPN, QMRP signatures are NOT acceptable.

Physician's Address _____ Phone _____
City _____ State _____ Zip _____
MAIL COMPLETED APPLICATION WITH GUARDIAN SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:
ARKANSAS DISTRICT A/G CAMP 4:13; 10924 INTERSTATE 30; Little Rock, AR 72209