TBI CAMPER APPLICATION
Camp Date: March 20-23, 2025

Return Application by Jan, 15, 2025:
BIAC
P.O. Box 236
Robards, KY 42452

Camp fee $1200 .
Make checks payable to BIAC
TBI Buddy can attend at no charge
Buddy must complete page 1 of application .

For Office Use Only:
Application Received:_____ Payment Received:_____Amount:_____
DATE DATE
Acceptance Letter Sent Date:_____

Buddy Name:_____ Phone:_____

Camper

Name:_____
Address:_____
City:_____
State:_____ Zip:_____
Phone: Cell_____Home_____
Email:_____

Age:_____ Male:_____ Female:_____
Height:_____Weight:_____
Birthdate:_____
Will a buddy/helper be attending with you? _____
If yes, Buddy Name_____

Guardian

Name:_____
Address:_____
City:_____
State:_____ Zip:_____
Phone: Cell_____Home_____Work_____
Email:_____

Relationship to Camper:
____Spouse ____Parent ____Case Manager
____Sibling ____Other (please specify)

Emergency Contacts

Please be sure these people will be available during the week of camp.

Name:_____
Address:_____
City:_____
State:_____ Zip:_____
Phone: Cell_____Home_____
Email:_____

Name:_____
Address:_____
City:_____
State:_____ Zip:_____
Phone: Cell_____Home_____
Email:_____

Do you have a Medical Power of Attorney? ____Yes ____No If yes, Person_____Phone _____
Current Physician:_____Phone_____
Medical Insurance: ____Yes ____No Name of Insurance Company:_____
Policy Number:_____ Policy Holder:_____

Please circle and/or fill-in blanks:

Mobility: Walks independently Manual wheelchair Electric wheelchair Walker Cane Crutches Other: _____

If in a wheelchair:

Do you use the chair? All the time Just when fatigued Just outside Not at home, just camp Not at camp

Do you operate the wheelchair independently? ____Yes ____No Explain:_____

Transfers: ____No assist ____Total Assist ____Pivot with spotter ____Other:_____

Weight shifts: ____None ____Yes, required How often? _____ Assistance:_____Props

Do you have balance concerns? ____No ____Yes Explain_____

Do you have walking concerns? ____No ____Yes Explain_____

Do you require assistance on rough, uneven terrain ? ____No ____Yes Explain:_____

How far can you walk? with assistance_____ without assistance_____

Can you walk up and down stairs independently? ____No ____Yes Explain_____

Other adaptive devices:

None Nightbraces/AFO's Prosthesis Helmet Glasses/Contacts Hearing Aid Dentures

Other:_____

Seizures: ____Yes ____No Type: _____

Date of last on: _____ Are they controlled by Medication? ___Yes ___No Meds used:_____

Can you tell if a seizure is coming on? ____Yes ____No How?_____

Speech Concerns: Normal Mildly affected Moderately affected Severely affected Few words Non-verbal

Communication:

Speaks Uses sign language Uses Communication Board Uses device Gestures

Other_____

Can you understand what is said to you ? ____Yes ____No Explain_____

Can you express your needs? ____Yes ____No Explain_____

Do you know sign language? (But may not use it daily) ____Yes ____No

Hearing: Normal Hard of hearing Wears hearing aid sensitive to "excessive noise" Extremely sensitive

Vision: Normal Legally blind Total loss No peripheral vision Wears glasses Contacts Other:_____

Are you in the habit of wearing sunglasses? ___Yes ___No (Please bring sunglasses with you with a retention cord)

Vitals: Any heart problems? __Y __N Heart murmur? __Y __N Irregular heart beat? __Y __N Blood pressure concerns __Y __N

Behavior:

How is your memory? It's O.K. Mild short-term memory loss Severe short term memory loss

Extreme STM loss - Explain _____

In a new situation do you? Get lost Lose belongings Run away Wander off

Do you have anger Issues? None Mild Sometimes Severe Often Cause?_____

What helps to calm you down?_____

Do you get frustrated? Never Sometimes Occasionally Often Always Cause?_____

Do you get depressed? Never Sometimes Occasionally Often Always Controlled by meds?_____

Do you get paranoid? Never Sometimes Occasionally Often Always Controlled by meds?_____

What are your fears?_____

Do you ever lose verbal control? (scream and shout)? ____Yes ____No Do you ever lose physical control (hit, etc.)? ____Yes ____No

Are you currently receiving Psychotherapy? ____Yes ____No Dr._____Phone_____

Personal Hygiene

For women: Do you need assistance with feminine products: ____Yes ____No Uses? Pads Tampons

Do you smoke? ____Yes ____No How much?_____

Toileting:

Toilet needs: No assist Partial assist Total assist

Bladder needs: None Incontinent Needs reminders Needs to go very often Explain_____

Bowel needs: None Incontinent Needs reminders Constant diarrhea Explain:_____

Please list toileting schedule _____

Describe behavior related to disrupted toilet habits_____

How long does bowel routine normally take?_____

Aids used:

None Urinal P.M. urinal Catheter P.M. Catheter Toilet chair Diapers

P.M. Diapers Ostomy bag Bedpan Suppositories - when?_____ Enema - When?_____

Other_____

Eating:

Do you require assistance? No assist Partial assist Total assist

Food must be: Cooled down Cut-up Mashed Pureed Liquefied Other_____

Aids used: Straw Feeding tube Adaptive utensils_____

How quickly do you eat? Average speed Fast Slow Very slow Extremely slow

Eating or swallowing concerns?_____

Dietary Concerns: You must supply any special needs

Dietary needs:_____

Food allergies? ____Yes ____No List_____

Food dislikes _____

Religious dietary needs? ____Yes ____No List_____

Vegetarian? ____Yes ____No

Medications: You must supply all medications - This list must coincide with Camp Medical Form

Medication	Taken For	Dosage	as of (today's date)

***Please list any over the counter (OTC) medications and/or vitamins and herbs.*

PHYSICIAN'S STATEMENT

I have reviewed the application and acknowledge that the camper, _____, is physically albe to attend camp.

Please indicate if there are any restrictions for this camper:_____

_____

Date of last exam:(must be within 24 months)_____ Physician/Nurse Practicioner Name (PRINT)_____

Address:_____Phone:_____FAX:_____

Physician/Nurse Practioner Signature:_____Date:_____

What are you doing when you are not at camp?

Where do you live?

Own home With family Apartment alone Group home Apartment with roommate Assisted Living Facility

Are you currently involved in a day program? ____Yes ____No Where_____

Are you in school? ____Yes ____No Grade:_____ School _____

How do you get around? Walk Bike Drive Bus Special transit Arranged rides Wheelchair

Some fun questions!

Do you sing: ____Yes ____No Do you play an instrument? ____Yes ____No Instrument_____

Jokes? I like to hear them I like to tell them Stories? I like to hear them I like to tell them

Your favorite activities/hobbies:

Inside:_____

Outside:_____

Who is your HERO?_____Why?_____

_____

_____

Camp questions: T-shirt size: S M L XL XXL

List other camps that you have attended:_____

Do you have special goals for camp this year?_____

_____

_____

Please provide two (2) character references: NAME, RELATIONSHIP, PHONE, EMAIL

(Required information for acceptance)

Name	Relationship	Phone	Email

On this page, please tell about yourself. Please include a photo if possible.

Photo

Agreement, Consent and Release

With the understanding that the Brain Injury Adventure Camp, Inc. (BIAC) will make every reasonable effort to prevent accidents, injuries and/or other mishaps, I acknowledge the following:

The undersigned give the Brain Injury Adventure Camp, Inc. (BIAC) permission to verify any information on this application and to contact references, case managers, and emergency contacts for any further information, which may be necessary.

The undersigned agrees to indemnify and hold harmless the BIAC for any and all claims, demands, costs, expenses, including reasonable attorney's fees, that the BIAC may incur as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the BIAC from any act of negligence or fault on the part of the BIAC, its officers, agents or employees.

The undersigned does consent that photographs or video pictures may be taken of the named applicant during the camp period, and that said photographs and video may be published in newspapers, magazines, television, publicity releases and/or other media.

The undersigned, in case of an emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery and other procedures, etc.

The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted).

The undersigned gives permission for the applicant to ride in vehicles operated or leased by the BIAC.

The undersigned recognizes the right of the Camp Director or the BIAC Lead, in his/her discretion, to terminate a camper or volunteer's stay at any time due to disciplinary or medical actions which might jeopardize their own health or safety, or other's health and safety at camp. The undersigned further agrees to pick up the camper or volunteer immediately upon being notified of such termination.

The undersigned agrees not to send the applicant (to attend or volunteer), one of the BIAC programs if he/she has been exposed to a contagious disease within three (3) weeks of the start of camp, and to notify the BIAC is such a case should arise.

If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned. I do hereby authorize (name, address, phone)_____
_____to pick up the camper or volunteer.

Please list anyone you DO NOT want to pick up camper/
volunteer_____

Today's Date:_____when this Agreement, Consent and Release has been read and signed.

Applicant's Signature:_____Printed_____

Legal Guardian Signature_____Name_____