



## The 36<sup>th</sup> Year of Fellowship in a Caring Community

Dear Friends:

Thank you for your interest in Camp Koinonia. Camp dates for the upcoming year have been set for April 15-20<sup>th</sup>, 2012. Many of you have been to camp before and are familiar with our procedures. However, this year there have been some changes so before you begin to fill out your application, please take time to read the important information listed below.

### Applying to Camp:

The enclosed application packet must be **FULLY** completed in order to attend camp. All application material must be filled out clearly, and as accurately as possible. Information will not be processed until the camper application pages and the application deposit have been submitted. Faxed applications **WILL NOT BE ACCEPTED** this year. All applications must be hand delivered or sent by mail.

### Deadlines:

If all pages/ forms have not been received by the appropriate deadlines, camper's spot **may** be forfeited.

**JANUARY 31<sup>st</sup> - Camper Application (pages 2-11)**

**MARCH 2<sup>ND</sup> - Medical Form (pages 13-14)**

### Application Deposit:

A \$100.00 application deposit is required per camper. The application deposit is a non-refundable fee once the camper is accepted into the program. The application fee does go towards your camp fee.

### Price:

The price of Camp Koinonia 2012 is \$325.00. Information on scholarship is available upon request.

### Eligibility:

Camp Koinonia believes that all children and adults with disabilities should have the opportunity to participate in traditional camp activities. Our knowledgeable staff and accessible camp facility can accommodate campers with a wide range of special needs. However, in efforts to maximize the experience of all campers, staff reserves the right to deny entry to any camper, if severe medical or behavioral problems are present. Other eligibility criteria:

- . Children and young adults with multiple disabilities
- . Individual must be ages 7-21.
- . Care givers must bring any special foods etc. that are required when taking medications.
- . Care givers must provide sufficient quantities of personal care items (gloves, wipes, bed protectors, briefs, etc.) to last throughout the week.

### Medical Form and Procedures:

The medical form does not have to be sent in with the camper application. The completed medical form, however, must be received by the deadline. If it has not been received by **MARCH 2, 2012**, the individual's spot may be forfeited. If, upon receipt of the medical form, we find we are unable to meet the individual's medical needs, we will contact you as soon as possible. Please bring all medication in original containers. Do not split medication into doses. Our med staff will verify that the medication is correct during check in.

Sincerely,

*Gene Hayes*

Dr. Gene A. Hayes, PhD  
Professor  
Founder, Camp Koinonia  
Executive Director  
865-974-1288



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**Camp Koinonia 2012**

April 15-April 20, 2012

**CAMPER APPLICATION**

CAMPER APPLICATION DEADLINE: JANUARY 31<sup>st</sup>, 2012

Cost to attend is \$325

Where to return applications and who to contact for questions:

Camp Koinonia  
1914 Andy Holt Ave, HPER 362  
Knoxville, TN 37996  
865-974-1288  
865-974-4363  
ghayes1@utk.edu  
Grant.StaffCampK@gmail.com

ALL FORMS MUST BE COMPLETELY FILLED OUT. **PLEASE PRINT CLEARLY.**

**CAMPER INFORMATION**

Camper's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Weight \_\_\_\_ Height \_\_\_\_

Primary Disabling Condition: \_\_\_\_\_

Date of Onset \_\_\_\_\_ Degree:  Slight  Moderate  Severe

T-shirt size: **ADULT** -  SMALL  MEDIUM  LARGE  XL  XXL  XXXL

**CHILD** -  SMALL  MEDIUM  LARGE

Has your child attended Camp Koinonia before?  Yes  No

School Attended: \_\_\_\_\_ Teacher: \_\_\_\_\_

**PARENT/ CAREGIVER INFORMATION**

Parent or Guardian Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (cell) \_\_\_\_\_ (other) \_\_\_\_\_

Email: \_\_\_\_\_ Fax : \_\_\_\_\_



When is the best time to reach you?  Morning  Afternoon  Evening

In case of an emergency, if the parent cannot be reached, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Child \_\_\_\_\_

In case of emergency, I understand every effort will be made to contact me. However, in the event I cannot be reached, I give my permission to the medical staff selected by the adult leader in charge to secure appropriate treatment.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

### **HISTORY**

*To be completed by camper's parent/guardian. PLEASE PRINT CLEARLY!*

**Disability** (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> ADD/ ADHD                              | <input type="checkbox"/> Intellectual Disability   |
| <input type="checkbox"/> Autism                                 | <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe/Profound |
| <input type="checkbox"/> Cerebral Palsy                         | <input type="checkbox"/> Learning Disability   |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Muscular Dystrophy  |
| <input type="checkbox"/> Developmental disorder                 | <input type="checkbox"/> Spina Bifida  |
| <input type="checkbox"/> Down's syndrome                        | <input type="checkbox"/> Spinal Cord Injury  |
| <input type="checkbox"/> Epilepsy/ Seizure disorder             | <input type="checkbox"/> Visual Impairment   |
| <input type="checkbox"/> Fragile X                              | <input type="checkbox"/> Partial <input type="checkbox"/> Total  |
| <input type="checkbox"/> Hearing Impairment                     | <input type="checkbox"/> Other(s) _____  |
| <input type="checkbox"/> Partial <input type="checkbox"/> Total | _____  |

**Diet:**  Normal  Blended/pureed  Special \_\_\_\_\_

**Mobility:**  Walks  Uses Walker  Uses Wheelchair, can operate/drive self?  Yes  No

**Seizures:**  YES  NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Describe any warning signs before seizures: \_\_\_\_\_

What steps are taken at home once the child has a seizure? \_\_\_\_\_



Is your child medicated for seizures?  YES  NO Medication: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

**Allergies**

- None  Pollen  Poison Ivy  Latex  Animals  Bee/Insects  Poison Ivy
- Latex  Food  Asthma  Medications  Other \_\_\_\_\_

Describe any allergic reactions \_\_\_\_\_

At home, we treat the following by:

- Allergic reactions \_\_\_\_\_
- Constipation \_\_\_\_\_
- Headaches \_\_\_\_\_
- Sore throat \_\_\_\_\_
- Cold \_\_\_\_\_
- Upset stomach \_\_\_\_\_

Does the camp medical staff have permission to administer over-the-counter medications to your child if needed?  YES  NO

Have you been told by a physician that your child should not engage in strenuous activities (running, physical games, etc.)?  YES  NO

Typical camp activities are horseback riding, dancing, sports and games, canoes, cooking, ropes course elements, science, and crafts.

Please describe or attach any instructions or precautions that should be taken during routine camp activities:

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

Are there any activities your child should not participate in?  YES  NO List: \_\_\_\_\_

\_\_\_\_\_

**Special Equipment (check all that apply)**

- Orthopedic devices  Glasses  Contacts  Dentures  Earplugs  Helmet
- Catheter  Feeding tube

If yes, what type of assistance is needed? Any special instructions \_\_\_\_\_

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



**Sleeping and Behavior**

Typical sleeping habits  Has trouble going to sleep  Has nightmares

Sleep walks  Special routine \_\_\_\_\_

Usual bedtime \_\_\_\_\_ Usual wake up time \_\_\_\_\_

Has emotional upsets?  YES  NO

What seems to cause the upset? \_\_\_\_\_

During an upset, what is normally done at home to calm him/her down?

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

Does your child exhibit any unusual or out of the ordinary behavior when he/she becomes very excited, overly tired, frustrated, or agitated?  YES  NO

Describe \_\_\_\_\_

\_\_\_\_\_

Are there any specific behaviors or skills you have been working on, or would recommend working on as a proposed behavior modification goal (i.e. independent washing of hands, use of silverware, appropriate eye contact, decrease inappropriate behaviors, etc.)?

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

**Communication:**  No serious difficulties expressing thoughts or wants  Has difficulty

Uses Sign Language  Uses a communication device

Describe \_\_\_\_\_

\_\_\_\_\_

**Bowel**

How frequent are your child's bowel movements?  Daily  Every other day  Once a week

Twice weekly  Three times per week  Other \_\_\_\_\_

Does your child's "bathroom habits" change in different environments?  YES  NO

Explain: \_\_\_\_\_

Does your child wear diapers/ briefs?  YES  NO

Explanation, if needed \_\_\_\_\_

\_\_\_\_\_

**Feminine Needs**

Does your child menstruate?  YES  NO

Special treatment for cramps? \_\_\_\_\_

List feminine products used and if assistance is needed: \_\_\_\_\_

\_\_\_\_\_



**Insurance**

Is the camper covered by hospitalization insurance?  YES  NO

Carrier: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

A copy of the camper's insurance/Medicaid, Medicare card is required. Please supply a copy of BOTH the FRONT and BACK of the card. Please provide a current picture of your child.

**COPY of Front of Insurance  
Card**

**COPY of Back of Insurance  
Card**

**Recent Photograph of  
Camper**



Indicate if your child can perform the requested skill **independently** and/or explain any assistance needed.  
**PLEASE PRINT.**

<b>PERSONAL CARE</b>	<b>YES</b>	<b>NO</b>	<b>EXPLANATION OF ASSISTANCE NEEDED</b>
Uses the toilet			
Washes hands and face			
Brushes teeth			
Takes shower			
Combs/brushes hair			
Dresses self: Underwear/brief			
T-shirt/jacket			
Pants/shorts			
Shoes & socks			
Other			
<b>MOBILITY/FINE &amp; GROSS MOTOR SKILLS</b>	<b>YES</b>	<b>NO</b>	<b>EXPLANATION OF ASSISTANCE NEEDED</b>
Can support self while sitting			
Operates own wheelchair			
Transfers from seat to chair/from bed to chair			
Uses crutches/walker			
Can roll over in bed			
Grasps and releases objects			
Other			



<b>MEALTIME NEEDS</b>	<b>YES</b>	<b>NO</b>	<b>EXPLANATIONS OF ASSISTANCE</b>
Can feed self with fork/spoon independently			
Can feed self with finger foods			
Has difficulty swallowing			
Can hold cup or glass			
Drinks from cup or glass			
Uses adaptive utensils			
Knows when he/she is full			
Is tube fed			
Prefers to drink out of a straw.			
Other feeding instructions			
<b>SAFETY CONCERNS</b>	<b>YES</b>	<b>NO</b>	<b>EXPLANATIONS OF ASSISTANCE</b>
Tends to run away from caretaker			
Shows appropriate fear of unsafe situations			
Pays attention to danger safety issues			
Follows simple directions			
Engages in self-abusive behavior			
Engages in abusive behavior towards others			
<b>SOCIAL SKILLS</b>	<b>YES</b>	<b>NO</b>	<b>EXPLANATIONS OF ASSISTANCE</b>
Makes wants known by speech			
Makes wants known by gestures			
Enjoys playing with others			





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## CAMP KOINONIA 2012 MEDICATION LIST

Please list ALL medications the child takes. Please send an ample supply of all medications to camp, in the **ORIGINAL MEDICATION CONTAINERS** - the child's name, physician name, pharmacy name, and appropriate administration instructions on container. WE MUST HAVE MEDICAL INFORMATION PRIOR TO CAMP. Please Print Clearly.

**Child's Name:** \_\_\_\_\_

	Medication Name	Dosage	Specific Times to Administer	Purpose of Medication	Special Instructions
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



### Camp Koinonia Release Agreement

In consideration of acceptance into the 2012 Camp Koinonia Program and of any fees paid to or deferred by The Camp Koinonia Foundation, the Camper \_\_\_\_\_ and the Camper’s Parent or Guardian \_\_\_\_\_ (together referred to as “the parties”) release the Camp Koinonia counselors and staff, volunteers, the Camp Koinonia Foundation (together referred to as “Camp Koinonia”) from any liabilities or claims resulting from the following.

1.0 Property Loss or Damages Release. While Camp Koinonia will take every reasonable precaution, the undersigned parties agree that Camp Koinonia is not legally responsible for any accidents, incidents or injuries that may occur during the camp session, that Camp Koinonia assumes no responsibility for applicant’s personal property and is released from liability for any accident, incident or injury except as may be covered by camper’s insurance. Camper has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted by myself or physician.

2.0 Medical Treatments Release The undersigned parties hereby authorize and grant permission to any licensed/certified medical professional designated by Camp Koinonia to provide routine medical care and administer medications or to perform any emergency procedures on the camper that would be jeopardized by any delay in providing such treatment or performing such procedures.

3.0 Photography / Media Release. The undersigned parties agree that the Camper will be outside participating in various recreational activities, while at Camp Koinonia. **PERMISSION IS HEREBY GRANTED** for official representatives of Camp Koinonia, and the business or individuals it designates to photograph my child while participating in the 2012 Camp Koinonia. These photos will be used for the sole purpose of promoting, reporting or publicizing the work and program of Camp Koinonia. Such promotion may include the use of my child’s name and picture for newspaper or other print media/promotions, DVD’s, television news and/or the Camp Koinonia website. I also give my permission for observations of my child to be conducted, and research and statistical data collected, as long as confidentiality of information is maintained. The undersigned hereby agrees also to hold Camp Koinonia harmless of liability should such pictures or photographs, either accompanied or unaccompanied by printed material, appear in other publication by whomsoever published, circulated or distributed.

I understand that this authorization for media release is subject to revocation at any time, except to the extent that the media has been utilized.

I also understand and agree that this release will terminate only upon the execution of my written statement on another sheet of paper indicating my intent to revoke this authorization. This can be stapled to your application.

I ATTEST THAT ALL INFORMATION PROVIDED IN THESE APPLICATION MATERIALS INCLUDING THE APPLICATION, MEDICAL EXAMINATION SUMMARY AND ANY SUPPLEMENTAL ITEMS ATTACHED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Camper Name: \_\_\_\_\_

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

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



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**This is the end of the camper application section due January 31<sup>st</sup>, 2012.**

**The next sheet is the MEDICAL FORM that is to be filled out by a physician.**

**The MEDICAL FORM is due March 2<sup>nd</sup>, 2012.**



**2012 Medical Form**  
**To be filled out by a physician**

Camp Koinonia  
1914 Andy Holt Ave. HPER 362  
Knoxville, TN 37996  
Phone: (865) 974-1288

**Date of Examination:** \_\_\_\_\_  
**Date Form Completed:** \_\_\_\_\_

**APPLICANT'S NAME:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**IMPORTANT NOTE TO PHYSICIAN:** The information requested in this form is extremely important to the applicant's health and safety during participation at Camp Koinonia. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp has a medical staff on site; however, we are able to provide only routine, basic health care. It is crucial therefore, that care be taken in thoroughly completing this form. Thank you for your assistance in this matter.

**PLEASE EXAMINE AND RECORD THE RESULTS OF THE FOLLOWING:**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_  
Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Teeth: \_\_\_\_\_ Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_  
ABD.: \_\_\_\_\_ Gent.: \_\_\_\_\_ Skin: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_

**Primary Diagnosis:** (please be specific) \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

**Secondary diagnosis** (related or unrelated to primary diagnosis): \_\_\_\_\_  
\_\_\_\_\_

**Other Medical conditions** (e.g. ileostomy): \_\_\_\_\_

**Any infectious diseases?** Please name and give recommendations. \_\_\_\_\_

**Does the applicant have epilepsy?**  YES  NO **Type of seizures:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Has the applicant been identified as developmentally delayed?**  YES  NO **Indicate Level:**  Mild  Moderate  Severe/Profound

**DOES APPLICANT HAVE ANY ALLERGIES?:**  YES  NO

To:  Pollen  Poison Ivy  Latex  Animals  Bee/Insects  Poison Ivy  Latex  Food  Asthma  Medications  
 Other \_\_\_\_\_

**Recommended treatment:** \_\_\_\_\_

**DIET:** Does applicant have any medically prescribed meal plan or dietary restrictions? Please describe: \_\_\_\_\_  
\_\_\_\_\_

**CAMP ACTIVITIES:** Please include any instructions or precautions to be taken during routine camp activities. These activities may include horseback riding, canoeing and sports:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any activities in which the applicant may NOT participate: \_\_\_\_\_



Reactions that might be expected with irregularities in:

- A. Environment \_\_\_\_\_
- B. Diet \_\_\_\_\_
- C. Medications \_\_\_\_\_
- D. Stress \_\_\_\_\_

**Medical History:**

Dates of Immunizations:

Measles, mumps, rubella: \_\_\_\_\_ Tetanus-diphtheria Toxoid: \_\_\_\_\_ H. influenza: \_\_\_\_\_  
 Pneumonia: \_\_\_\_\_ Last TB Skin Test Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 DPT series: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_  
 Polio series: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ Chicken Pox 1. \_\_\_\_\_  
 Hepatitis B: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Last dates applicant has had:

Chicken pox: \_\_\_\_\_ Mumps: \_\_\_\_\_ Diphtheria: \_\_\_\_\_ German measles: \_\_\_\_\_  
 10 Day measles: \_\_\_\_\_ Whooping cough: \_\_\_\_\_ Strep throat: \_\_\_\_\_ Pneumonia: \_\_\_\_\_  
 Rheumatic fever: \_\_\_\_\_ Mononucleosis: \_\_\_\_\_

Does applicant have a history of:

Ear infections: \_\_\_\_\_ Strep throat: \_\_\_\_\_ Gastric upsets: \_\_\_\_\_ Mono: \_\_\_\_\_ UTI: \_\_\_\_\_  
 Kidney problems: \_\_\_\_\_ Eczema: \_\_\_\_\_ Hypertension: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Other: \_\_\_\_\_  
 Emotional upset: \_\_\_\_\_

**SIGNATURE OF PRIMARY HEALTH CAREGIVER:** \_\_\_\_\_

The following information could be crucial in an emergency situation. Please print or type clearly.

NAME OF PRIMARY HEALTH CAREGIVER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**Medical professional to contact in the event applicant's Primary Health Caregiver cannot be reached:**

Name and title: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

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



## APPLYING TO CAMP KOINONIA 2012 CHECKLIST

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### Step 1: Complete all forms and information

Application processing will not begin until all required application materials are completely filed out and returned to Camp Koinonia. The medical form is due at the on **MARCH 2**, 2012. The application is made up of several sections. Please review and check the boxes below to make sure you have completed all the required sections. Keep this sheet for your records.

Application Fee \$100.00	Due: Jan 31, 2012
Camp Application Form-all areas must be completed	Due: Jan 31, 2012
Copy of Camper's Insurance Card (front and back)	Due: Jan 31, 2012
Recent Camper Photo	Due: Jan 31, 2012
Medical Form	Due: March 2, 2012

### Step 2: Return application packet

After all required sections have been completed, please mail packet to:

Camp Koinonia  
1914 Andy Holt Ave, HPER 362  
Knoxville, TN 37996

If you have questions regarding the application or the application process, please contact:

Gene Hayes  
865-974-1288  
ghayes1@utk.edu

Grant Staff  
865-974-4363  
Grant.staffcampk@gmail.com

*It is our pleasure to offer an excellent camping experience to each and every camper.*

***We'll see ya at camp!***