CAMP GLOW 2020 APPLICATION FORM

Part I:
Applicant Information:

Name of Applicant: ____

Address: ____

____

Date of Birth: ____________________________

Phone Number (s): ____________________________

Name of Person Completing this Application: ____

Relation to Applicant: ____

Organizational Affiliation: (if any) ____

Session Preference:

_____ Session 1: June 28 – July 3 O'Dwyer Retreat House

_____ Session 2: July 19 – July 24 O'Dwyer Retreat House

_____ Session 3: August 9 – August 14 O'Dwyer Retreat House

Camp GLOW West:

_____ August 3 – August 7 Accident, MD

_____ Any of the above sessions is acceptable

Emergency Contact Information:

Name: ____

Address: ____

____

Telephone:
Work________________________

Home________________________

Cell _________________________

Email ________________________

Name:____

Name of Primary Physician: ____

Address: _________________________ City:____________ State: ______ Zip:________

Phone Number:____________________

Primary insurance: ______________________________________ Phone________________

Insured name______________________ Group #__________ Policy #__________

Other Information:

Has applicant participated in Camp GLOW previously? ________When?___________________________

I grant permission for my picture to be used for Camp GLOW promotional pictures, videos, etc.

☐ Yes ☐ No

Will this individual have another opportunity to take a vacation this year? ______________________

T-shirt size:______________________

Signature: ____Date: ___________

Printed Name: ____

Thank you for taking the time to complete this form thoroughly. This information will be held in confidence.

Dcn.Bill Fleming
Office of Special Needs Ministry
Archdiocese of Baltimore
410-547-5410
bfleming@archbalt.org

CAMP GLOW 2020 APPLICATION FORM

Part II: Health History

Name of Applicant: ______________________________________

Address: ______________________________________

____

Date of Birth: ___________________________

ALLERGIES: ☐ No Allergies
Allergies to: ☐ Medication ☐ Food ☐ Environmental ☐ Insects

Please specify: ____

Have you had an adverse reaction to: ☐ antibiotics ☐ adhesive tape ☐ aspirin ☐ iodine ☐Tylenol ☐ latex ☐ other medications ☐ other

Last Tetanus: ________________(Required)

PAST MEDICAL HISTORY: Have you **<u>EVER</u>** had… check all that apply.

☐Eye Problems/Foreign Body	☐High Blood Pressure	☐Joint Replacement	☐Migraines
☐Color Blindness	☐Liver Problems	☐Arthritis	☐Seizures
☐Ear or Hearing Problems	☐Jaundice	☐Bipolar	☐ Ruptured Disc
☐ Glasses/Contacts	☐Depression	☐Cancer	☐Sports Injuries
☐Nutrition Problems	☐Hepatitis	☐Radiation/Chemo	☐Muscle Problems
☐Nose Problems	☐Stomach Problems	☐Carpal Tunnel	☐Sprains or Strains
☐Mouth/Oral Problems	☐Stomach Ulcers	☐Diabetes	☐Any Prior Work Injury
☐Lung Problems	☐Colitis	☐Gout	☐Chiropractic Care
☐Lung Infection	☐Urinary Problems	☐Hay Fever	☐Tendonitis
☐Asthma	☐Kidney/Bladder Infection	☐Hives	☐ Incontinence
☐Emphysema	☐Kidney Disease	☐Anxiety	☐ Neurological Problems
☐Pacemaker/Stent	☐Kidney Stones	☐Substance Abuse	☐ Head/Spine Problems
☐Angina/Chest Pain	☐Bleeding Problems	☐Hernia	☐ Prior Back Strains
☐Heart Disease	☐ Loss of Consciousness	☐Skin Problems	☐ Metal in any part of body

Please write/print legibly. Once the lines are full, please use the back of this form when answering below.

Please explain any boxes checked above:____

____

Name:____

Please provide information concerning any dietary restrictions:____________________________________

____

Please indicate any restrictions related to physical activities, exposure to the sun, etc:__________________

____

Please explain any behavioral concerns:____

____

Please explain any mobility or other limitations: ____

____

MEDICATION INFORMATION
Please Print

Medications are to be administered by (please check one):
_____________Camp Nurse
_____________Self-administered by camp participant (please list all medications)

DRUG*	STRENGTH	DOSAGE	TIMES GIVEN

*PLEASE INCLUDE OVER THE COUNTER MEDICATIONS

SPECIAL INSTRUCTIONS: ____
____

***Does camp participant use c-pap machine? _________Yes_________No**
(Note: Participant must have ability to operate c-pap independently)

Name:____

ATTENTION CAREGIVERS:

The following needs to be signed by the applicant's physician/nurse practitioner:

Dear Physician/Nurse Practitioner:

Please read the above health information concerning____________________________________, **noting**
Name

any errors, incorrect or missing information, based on your current knowledge of patient's history.

Based on above named patient's history and last visit with you, on________________________________,
he/she has an acceptable health status to attend Camp GLOW for one week this summer.

____ ____
Physician/Nurse Practitioner (Signature/Date) **Physician/Nurse Practitioner (printed)**