



YOUNG LIFE CAPERNAUM PARENTAL OR GUARDIAN INTERVIEW

NOTE TO THE PARENT/GUARDIAN/GUEST: Young Life wants the camp experience to be a safe and healthy one. Thank you for taking the time to fill out this form. This will help us know how to best serve your son or daughter.

Camper's Name _____ Camper's School _____
Last First Middle Initial

Camper's Disability _____

Is the camper on medication? Yes ___ No ___ Has medication been changed recently? Yes ___ No ___

If yes, when? _____ Please give medication authorization and information below.

Does the camper have seizures? Yes ___ No ___ If Yes, how often? _____ How severe? _____

If female, and menstrual cycle begins at camp, how does she take care of herself? _____

Is the camper aggressive? _____ If Yes, how do you control his/her behavior? _____

How does camper deal with people he/she does not know? _____

Does camper feed him/herself _____ Any food restrictions? _____

Is his/her speech understandable to people who do not know him/her? Yes ___ No ___

Check all that apply	
<input type="checkbox"/> Uses toilet independently	<input type="checkbox"/> Camper has a shunt
<input type="checkbox"/> Uses toilet with supervision	<input type="checkbox"/> Camper has a rod supporting bones
<input type="checkbox"/> Uses hearing aid	<input type="checkbox"/> Camper is allergic to latex
<input type="checkbox"/> Uses wheelchair	<input type="checkbox"/> Uses signs to indicate need to go to bathroom. Describe _____
<input type="checkbox"/> Uses walker	<input type="checkbox"/> Wears diaper/pull-ups? Any special instructions? _____
<input type="checkbox"/> Uses sign language	
<input type="checkbox"/> Uses language board	

Anything else we should know to help us be able to serve your son or daughter? _____

Medication Information and Authorization (Medications MUST be in their original prescription containers.)

Prescription name	Dosage	Time to be given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions _____

I, _____, parent/guardian of _____ give my permission to the Young Life staff person or adult volunteer leader to administer my child's medication in my absence. If needed, I also give permission for the staff person to administer personal hygiene care as follows: _____	
Signature of parent or guardian _____	
Date _____	

EQUIPMENT USED AND SPECIALIZED HEALTH CARE NEEDED

*(Check all that apply and explain below. *)*

Equipment Used by Child

- Glasses / Contact Lens
- Hearing Aid
- Helmet
- Wheelchair / Walker
- Other: _____

Medical Support Systems

- Hickman / Broviac / IVAC / IMED
- Mechanical Ventilator
- Oxygen
- Ventricular Peritoneal Shunt
- Other: _____

Specialized Health Care Needed:

Activities of Daily Living

- Bowel / Bladder Training
- Diapering / Toileting
- Lifting / Positioning
- Other: _____

Catheterization

- Clean Intermittent Catheterization
- External Catheter
- Other: _____

Ostomies

- Ostomy Care
- Other: _____

Feeding

- Gastrostomy Feeding
- Jejunostomy Tube Feeding
- Naso-Gastric Feeding
- Oral Feeding
- Total Parenteral Feeding
- Other: _____

Respiratory Assistance

- Percussion
- Postural Drainage
- Suctioning
- Other: _____

Specimen Collecting / Testing

- Blood Glucose
- Insulin Pump
- Other: _____

CHRONIC, RECURRING AND SPECIAL HEALTH CONDITIONS

*(Check all that apply and explain below. *)*

- Arthritis (rheumatoid)
- Attention-Deficit/Hyperactivity Disorder
- Behavioral or Development Problems
- Cerebral Palsy
- Cystic Fibrosis
- Dental Problems
- Diabetes
- Down Syndrome
- If camper has Down Syndrome, check if they have been cleared by a doctor indicating spinal stability
- Encopresis (involuntary discharge of stool)

- Enuresis (involuntary discharge of urine)
- Head or Spinal Injury
- Hearing Impairment
- Heart Disease
- Kidney Disease
- Muscular Dystrophy
- Seizures
- Sickle Cell Disease (not trait)
- Spina Bifida
- Visual Impairment
- Other: _____

*** Explanation:**

List names of medical specialists or special clinics caring for your child: