2009-2010 WINTER CAMP APPLICATION

If you filled out an application in 2009 for Camp Friendship, Camp Eden Wood or Camp New Hope Summer programs or Creative Options Respite **(call us if you are unsure)** all you need to do to register for Winter Options at Camp Friendship or Camp Eden Wood is complete this form and send it along with your $250 deposit. IF YOU DID NOT ATTEND ONE OF THESE PROGRAMS in 2009, PLEASE CONTACT OUR OFFICE SO A COMPLETE APPLICATION PACKET CAN BE MAILED TO YOU. **Please complete the back of this form regarding any health care needs.**

NOTE: THIS FORM CAN ONLY BE USED FOR INDIVIDUALS WHO ARE REGISTERING FOR 2009-2010 WINTER CAMP **AND** WHO HAVE COMPLETED AN APPLICATION FOR SUMMER OR CREATIVE OPTIONS RESPITE IN 2009.

NAME_____AGE_____
Last First Middle

DATE OF BIRTH_____ADDRESS_____

CITY_____STATE_____ZIP_____TELEPHONE (_____)_____

PARENT / FACILITY CONTACT PERSON_____

RESIDENTIAL FACILITY NAME_____

CORPORATE OWNER NAME_____

FEE AGREEMENT

Please check and complete the appropriate blank(s)
____Will pay discount fee of $_____Will pay cost of $_____
____Would like to contribute $_____to the "Scholarship Fund" to help another person attend a Friendship Ventures program.
Fee will be paid by:
$_____ _____
amount name of person or organization address city/state/zip

METHOD OF PAYMENT

____Full payment of $_____enclosed. ____Partial payment of $_____enclosed.
____Bill me later: ____Single payment of $_____ OR ____Monthly payment of $_____

____Credit Card: Bill $_____to my: ____MasterCard ____VISA

Card #_____/_____/_____/_____

Exp. Date_____ CVV Code: _____(3 digit code on back of card)

Print name on card_____

Signature_____

SCHOLARSHIP GRANT APPLICATION

If you cannot pay all of the winter camp cost, please complete the Scholarship Grant Application Form below.
(this area must be completed in its entirety in order to be considered for any scholarship)

Your Name_____ Spouse (if applicable)_____

Adjusted Gross Income(s)……$_____
Adjusted Gross Income of spouse (if separate returns filed)……$_____
(From: Line 36-IRS 1040 Form OR Line 21-IRS 1040A Form OR Line 4-IRS 1040EZ Form)

Total Number of dependents (including yourself and spouse, if applicable)_____
1. Total Session Cost(s)……$_____
2. Total Scholarship Grant Requested……$_____

Provide a brief explanation of financial need: _____
_____
May we use applicant's name when seeking contributions for our scholarship fund? _____Yes _____No

I/We verify that the above information is true and accurate. If requested by Friendship Ventures, I/We agree to provide verification of income.

_____ _____
Signature of parent/guardian Signature of parent/guardian

FIRST CHOICE OF SESSION(S)_____(please list session #, name and dates)
SECOND CHOICE OF SESSION(S)_____(please list session #, name and dates)

Friendship Ventures, 10509 - 108th St. NW, Annandale, MN 55302
(952) 852-0101 * (320) 274-8376 * FAX (952) 852-0123

ARE THERE ANY SPECIAL CONSIDERATIONS OR CHANGES SINCE THE PREVIOUS APPLICATION YOU FILLED OUT? IF SO, PLEASE PUT COMMENTS ON A SEPARATE SHEET. THANK YOU! **8/09**

Friendship Ventures
10509 108th St. NW
Annandale, MN 55302
Metro (952) 852-0101
Fax (952) 852-0123
Local (320) 274-8376
fv@friendshipventures.org

FOR OFFICE USE ONLY:
Date Rec'd._____
Session_____
_____

HEALTH HISTORY

This form must be completed by the caregiver *and sent in with the Application for registration in Winter Camp.*

Name_____ Date of Birth____/____/____ Male____ Female____
Last First Middle Initial

Doctor:_____ (_____)_____
Name Address City/State/Zip Phone

PLEASE SEND PHOTOCOPY OF ALL INSURANCE, MA & MEDICARE CARDS

MA #_____ Medicare #_____

Special medical needs: Please check any that apply

____Receives care from licensed nurse on a daily basis for: _____. Will your nurse or PCA be attending camp? ___
____Diabetes: Insulin Dependent___ Controlled by diet___ Blood sugar testing required___
Gastrostomy___ Colostomy / Ileostomy___ Catheter___ Orthopedic Appliances ___ Nebulizer___ Asthma ___ Seizures___

You may be sent a questionnaire requesting more information which must be completed/returned to our office 2 weeks prior to check-in.

Allergies: List ALL types, food, drug, etc.: _____

MEDICATIONS: All medications received for a Friendship Ventures service **must be in their ORIGINAL CONTAINERS**, **properly labeled by a PHARMACIST** as to person's name, medication, dosage and times of administration.

Non- prescription (Over-the-counter) items must have a WRITTEN ORDER BY A DOCTOR.

Friendship Ventures' Medical Committee encourages that any extra items (such as vitamins) be placed ON HOLD during participation in this service.

Medication:	**Reason for use:**	mg.	# tabs	Frequency	8 am	12:30 pm	5:30 pm	9 pm	Special Instructions: before, with or in food/crushed
	for:								
	for:								
	for:								
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Please check all that apply: swallows meds whole ___ crush meds ___ uses oral syringe (please send) ___ uses medicine spoon (please send) ___

Topical medications and treatments: (Please state specific instructions for use of drops, ointments, dressings, treatments, etc., attach separate sheet, if needed.)_____
_____
_____

Bowel Program (check all that apply): MOM 2nd day without BM___ Suppository if no results from MOM___
Fleets enema if no results from suppository ___ Bowel Program Not Applicable___

Check if individual is subject to the following:

____sunburn	____frequent colds	____dizziness/fainting spells	____constipation	____menstrual problems
____frostbite	____bronchitis	____ear infection	____diarrhea	____vaginal infections
____sore throat	____pneumonia	____sinus infection	____nausea/vomiting	____urinary infections
____skin rash	____hernia	____must not get water in ears	____stay out of water	____other:_____

Please comment on the above checked items regarding treatment routine:_____
Describe the mental, emotional or psychological needs that will impact participant's interaction or participation:
_____

This Health History is correct so far as I know and the person herein described has permission to engage in all activities except as noted. Exceptions: _____

PERSONS CHECKING- IN PARTICIPANTS must be able to answer questions regarding participants:

A. Medication and health details.
B. Special diet details.
C. Special appliances or other medical needs.

If there is a change in the participant's health or medications, or if they have had surgery within 3 weeks prior to arrival, please call the Director of Health Care at (952) 852-0105 to determine if we are able to accept this participant.

Form completed by: _____ **Date:** _____ / _____ / _____