

Camp Rainbow, Inc.
P.O. Box 701
Chillicothe, Missouri 64601
www.camp-rainbow.org

CAMPER'S APPLICATION

Camp information in this application needs to be completed before the camper may attend Camp Rainbow. We are very excited to announce that we are again able to offer three sessions of camp. The first session of camp will run from **Saturday, June 15 to Monday, June 17, 2024**. The second session of camp will run from **Tuesday, June 18 to Thursday, June 20, 2024**. The third session of camp runs from **Friday, June 21 to Sunday, June 23, 2024**. All sessions are the same length.

You will be notified as soon as possible after May 12th if your application has been accepted. Exact dates and times for reporting to camp, and a list of suggested supplies, will be sent to you then.

The camp fee remains **\$15.00**. It is possible for campers to attend camp regardless of whether they can pay or not because of the generous contributions from friends of Camp Rainbow.

All beds are filled on a first come first serve basis. That being said, you have a better chance of coming to camp if you get your application turned in quickly. We must have the application back by **May 6th** in order to reserve your camper a bed. If you cannot secure the doctor's report by that time, please indicate this on the application and return the rest of the forms and send the doctor's report later. **WE CANNOT ALLOW A CAMPER TO CHECK INTO CAMP WITHOUT A COMPLETED DOCTOR'S REPORT.**

Any physical within a year from the starting date of camp (June 15, 2024), is acceptable. A copy of another camp physical or a Special Olympics physical, as long as it is within the year, is also acceptable.

This is the **64th year of Camp Rainbow**. It is a tradition of love and concern for those with different abilities through the efforts of many young people and adults who have made it possible. We're excited for you to come celebrate our **Fiesta** themed camp this summer! Remember we need the application by **May 6, 2024**. Contact us if you have any questions. Contact Beth Milanovich at 660-973-3850, or email: bamilano@yahoo.com. The mailing address for Camp Rainbow is P.O. Box 701, Chillicothe, MO 64601.

We are able to accept a limited number of wheelchair campers. If your camper needs a wheelchair, walker, or other specialty items, please plan on bringing that with them to camp.

ATTENTION CAMPERS AND CAREGIVERS

Due to the large number of medications given at Camp Rainbow, we are changing the way the medications are brought to camp. We will require that medications (pills/tablets/capsules) be packaged in approximately 2" x 4" packets with the camper's name, date, and time to be given. We are asking that the camper's pharmacy package the medications, but the caregiver can package them also.

Campers are involved in various activities throughout the day so medications are given at mealtimes and bedtime. Those times are 8:00 am, 12:00 pm, 5:00 pm, and 8:30 pm. If the medications are not packaged when the camper arrives, we will have the packets available for the caregiver to package them for the camper with the date and time they are to be given. Please send only the medications the camper will need while at camp. We have ibuprofen, Aspirin, Maalox, and other over the counter medications available. We will give those to the camper when needed.

We appreciate your cooperation in this matter. If you have questions about how to package the medications, please call Betty Snyder at 660-646-1026 after 5:00 pm, Mon-Fri.

Camp Rainbow Board

Session _____ Cabin _____
(Office use only)

PLEASE ATTACH PHOTO HERE

CAMP RAINBOW

Name of Camper: _____ Sex: _____

Date of Birth: _____ Age: _____ Weight: _____ T-Shirt Size: _____

Parent or Guardian: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Cell: _____

Email Address: _____

Camper's Address: _____ City: _____

State: _____ Zip Code: _____ County _____ Phone: _____

Does applicant attend school or work? _____ Where? _____

Does applicant have an intellectual disability? yes no Physical disability? yes no

Has applicant attended Camp Rainbow before? yes no

Give the name of the person that should be contacted in an emergency during the camp.

Name: _____ Phone: _____

Address: _____

Place an "x" in one of the three blanks after each listing:

Applicant will need:	much help	little help	no help
walking	_____	_____	_____
dressing	_____	_____	_____
toilet needs	_____	_____	_____
eating	_____	_____	_____

Please explain what type of help is needed (if marked above). _____

If camper is wheelchair bound, do they use a hooyer lift? (Are they a total lift or can they help

1. Speech habits: Is applicant's speech understandable? _____ If not, can he/she make his/her wants and needs known? _____ How? _____
Does the applicant wear dentures? _____ Will they be wearing them at camp? _____

Comments:

2. Hearing: Is the camper deaf? _____ If not, does he/she have any special hearing difficulties? _____
Does the camper wear hearing aids? Left _____ Right _____ Will camper be wearing aids at camp? _____ Please be sure to send extra batteries or a charging device for hearing aids.

Comments:

3. Vision: Is the camper visually impaired? _____ Does campers wear glasses? _____
Contacts? _____ Will camper be wearing glasses during camp? _____

Comments:

4. Sleeping habits: What bedtime routine would be helpful for our counselors to know?

Does the applicant sleepwalk? _____ Does the applicant have any outstanding fears of the night? _____

Does the applicant use a CPAP machine? _____ Is applicant compliant with the use of CPAP machine? _____

Comments:

5. Water activities: May the applicant participate in supervised water activities? _____
(Life jackets are provided by Camp Rainbow and are required to be worn by all campers when participating in water activities.)

6. Camp Rainbow and Crowder State Park have gone smoke/vape free as of 2020. We feel that this will be a healthy change for all of our campers and staff. Thank you for your cooperation on this. **Please do not pack cigarettes in your camper's luggage.**

7. Are there any specific activities to be encouraged while at camp? _____

Restricted? _____ Is camper cooperative? _____

What motivates this camper? _____

When the camper gets anxious or frustrated, what helps to calm them? _____

Comments:

8. If applicant is female, should she begin her menstrual cycle while at camp? _____

If so, please send the appropriate pads with her.

9. Does camper have any special sensory needs: _____

Explain: _____

To be detached for camp nurse.

Session: _____

Cabin _____

PARENT OR GUARDIAN FILL OUT THIS MEDICAL HISTORY

Camper's Name: _____ Age: _____

Parent, Guardian, or Institution: _____

Address: _____ Home Phone #: _____

(If camper is a resident of a group home, please list the name and phone number of person to be contacted in reference to care, medication, or emergency that might occur.)

Name: _____ Phone #: _____

Answer yes or no.

Does camper have allergies to the following: If yes, please list.

Penicillin or other drugs: _____

foods: _____

grass, pollen, weeds: _____ Insect bites: _____ other: _____

Do any of the camper's allergies require an epipen? _____ If so, please send epipen to camp.

May camper receive over the counter medication for: Answer yes or no.

headache: _____ insect bites: _____ Upset stomach: _____ sore throat: _____ diarrhea: _____

Does camper have: Frequent colds: _____ Sore throat: _____ Bed wettings: _____

Sinusitis: _____ Convulsions: _____ Earache: _____ Heart trouble: _____

Asthma: _____ Fainting: _____ Athlete's foot: _____ Sleepwalking: _____

Upset stomach: _____ Constipation: _____ Epilepsy: _____ Diabetes: _____

Poison oak or ivy: _____ Seizures: _____

Does camper ever "fake" illness? _____ If yes, please explain: _____

If diabetic, does the camper manage this themselves? _____

Any remarks that would be helpful to the camp nurse:

PARENT OR GUARDIAN OF CAMPER, PLEASE COMPLETE WHERE APPLICABLE

We, the parents, and/or school, or guardian for _____
expressly agree to indemnify and hold harmless Camp Rainbow or it's agents, employees,
counselors, officers, and directors against loss of any and all claims, demands, or actions that may
hereafter be brought against Camp Rainbow or it's agents, employees, counselors, officers or
directors by parents or by anyone in their behalf or on behalf of said camper for the purpose of
enforcing a claim, demand, or cause of action as a result of an injury or illness of any type, kind,
or character to said camper.

We also consent to the use of the above camper's name and/or picture in connection with
any publicity for Camp Rainbow for Exceptional Children. (Please check here if you **do not** want your
camper's name/picture used _____.)

In case of Medical Emergency, I understand every effort will be made to contact parents or
guardians of campers. In the event I cannot be reached, I hereby give permission to the physician
selected by the camp director to hospitalize, secure proper treatment for, and to order injection,
anesthesia or surgery for my child, as named above.

PARENT, SCHOOL, OR GUARDIAN _____
(Signature)

DATE: _____

Session _____ Cabin _____

Applicant's name: _____

PHYSICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

Code: **S - Satisfactory**
 NS - Not Satisfactory (explain)

Height: _____ Blood Pressure: _____ Urinalysis: _____

Weight: _____ Eyes: _____ Ears: _____ Skin: _____

Nose: _____ Throat: _____

Teeth: _____ Heart: _____

Lungs: _____ General appraisal: _____

Epileptic? _____ Severity: _____

Frequency of seizures: _____

Orthopedics: _____ Last tetanus booster: _____
(required within ten years)

If Down's Syndrome - has camper been x-rayed for atiantoaxial sublaxation: _____

If x-rayed, what were the results of the x-rays: _____

Recommendations and restrictions (diet, medicine, swimming, diving, etc.)

Signed _____
(examining physician)

Address: _____ Phone: _____

Date: _____