15501 San Fernando Mission Blvd., Suite 100
PO Box 9604 Mission Hills, CA 91346-9604
818-361-6400 Ext. 111 • 818-365-5523 fax
kim@jaynolan.org
www.jaynolancamp.org

JAY NOLAN 캠프 지원 신청서 – 여름 2025

우리는 숲으로 가려고 합니다. 그리고 당신이 우리와 함께 하기를 기대합니다!
Jay Nolan 캠프에 참여하기로 선택해 주셔서 감사합니다!

제 이름은 Kim Cade-Henry입니다. 나는 캠프의 총괄자 입니다. 귀하의 자녀가 캠프를 준비하는 동안 질문이나 우려 사항이 있는 경우, 제일 먼저 저에게 전화를 주십시오.

귀하가 가지고 있을 첫 번재 질문은:

JAY NOLAN 캠프는 언제 어디에서 있습니까?

캠프 날짜는 2025년 7월27일부터 8월 1일까지입니다.
Jay Nolan 캠프는 *The Lions Camp at Teresita Pines* 에서 개최됩니다.
(http://www.campteresitapines.org)

그리고 비용은 얼마입니까?

2025 캠프비용

	12월1일–2월29일	3월1일–5월31일	6월1일–6월24일
장애가 있는 캠프 참가자	**$1100**	$1250	$1300
장애가 없는 캠프 참가자	**$1100**	$1250	$1300

- 우리는 캠프 참가자가 캠프에 갈 수 있도록 친구와 가족을 참여시킬 수 있는 몇 가지 모금 아이디어를 제안하게 되어 기쁘게 생각합니다.
- 귀하의 자녀에게 1:1 지원이 필요하다고 생각하시는 경우, 저희는 귀하의 가족과 만나 평가를 받고 지역 센터를 통해 추가 인력을 요청할 수 있도록 기꺼이 도와드겠습니다. 서류 작업을 시작할 수 있도록 일찍 연락해 주세요!
- 캠프 참가자가 추가 지원이나 감독이 필요하고 지역 센터의 고객이 아닌 경우, 추가 비용이 발생활 수 있습니다. 이는 캠프 행정 직원에 의해서만 결정됩니다.

페이지를 넘기고 Jay Nolan 캠프에 갈 준비를 하세요!

신청하는 방법

1. 지원 신청서를 끝까지 작성하세요. 가장 최근의 사진과 서명된 동의서를 포함하셔야 합니다. 이 지원 신청서는 자녀에게 안전하고 품질 높은 경험을 보장하는데 필요한 모든 정보를 포함하도록 설계되었습니다.
2. 참가비 결제하기–신청 시 최소 $300의 계약금이 필요합니다. '결제 일정'을 참고하시기 바랍니다. 캠프 떠나기 전까지 부분 지불로 결제 하실 수 있습니다. 이 예정을 세우기 위해 Kim에게 문의 하시기 바랍니다.
3. 다음 주소로 우편, 팩스, 이메일을 보내거나 신청서를 접수하고 결제하십시오.

Kim Cade-Henry – Camp Director
Jay Nolan Recreational Services, Inc.
15501 San Fernando Mission Blvd, PO Box 9604
Mission Hills, CA 91346-9604
kim@jaynolan.org
Fax # (818) 365-5523

'건강검진서'는 의사가 작성하고 서명하여 캠프 30–60일 전까지 제출해야 합니다. 지원 신청서의 나머지 부분을 보내시고 자녀가 의사 방문을 마치면 검진서를 제출해 주시기 랍니다.

지원 신청서가 처리되면 수락 편지가 우편으로 발송됩니다. 픽업/드롭 집합장소와 준비물 목록은 캠프 개최 1개월 전(2025년 6월) 우편으로 발송됩니다.

귀하의 자녀가 장애가 있고 이전에 Jay Nolan 캠프에 참가한 적이 없는 경우, 캠프 전에 귀하의 자녀와 만나 신청서를 검토하고 캠프에 있는 동안 귀하의 자녀가 가질 수 있는 지원 필요 사항에 대해 논의할 것입니다. Jay Nolan Recreational Services 사무실에서 업무 시간 중에 약속을 잡거나 귀하의 집에서 만날 수 있는 보다 편리한 시간을 정할 수 있습니다.

JAY NOLAN 캠프의 포용적인 환경을 돕는 방법

귀하는 장애가 있거나 없는 아이들이 서로 소통하고 배울 수 있는 포용적인 캠프에 아이를 보내기로 선택하셨습니다. 우리는 항상 캠프에 장애가 없는 더 많은 아이들을 찾고 있습니다. 각 캠프 세션의 비율은 발달 장애가 있는 아동 30–35%, 장애가 없는 아동 65–70%입니다. 현 시점에서, 사람들 간의 차이를 이해하고 존중하는 사람들은 장애가 없는 아이들을 우리와 같은 캠프에 보내는 이점에 대한 가장 큰 대변인입니다. 8–15세의 형제, 가족, 친구, 학교 친구, 이웃등을 우리의 캠프에 보내주세요! 더 많은 지원 신청서는: http://jaynolancamp.org/에서 다운 받거나 Kim Cade-Henry에게 (818) 361-6400 x111로 연락할 수 있습니다.

이 캠프 지원 신청서는 페이지 양면에 인쇄되어 있습니다.
반드신 신청서 양면 모두 다 작성해 주셔야 합니다!

Place Child's Recent Photo Here

JAYNOLAN recreational services Summer Camp

15501 San Fernando Mission Blvd. Suite 100
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(818) 361-6400 Ext. 111 (Camp Director)
(818) 365-5523 (Fax)
kim@jaynolan.org (E-mail)
http://jaynolancamp.org (Website)

Jay Nolan Camp - Camper Application

Instructions: **We are accredited by the American Camp Association and maintain the standards set by them, in addition to our own. You are required to have a *complete* application, photo, up-to-date immunizations, and a medical exam signed by a licensed physician (listing all current/correct medications). Anything that would be non-applicable, please put 'N/A'. If you need assistance with anything, please let us know.**

2025 Camp Session at Lions Camp at Teresita Pines (Wrightwood, CA)
July 27- August 1, 2025

Child's Name_____
First Last

Address_____
Street

City_____ **State**_____ **Zip**_____

Home Telephone_____ **Date of Birth**_____
MM/DD/YY

Gender:

- ❑ **Male**
- ❑ **Female**

Birthday at Camp?

_____

Age while at camp:

_____

How did you hear about Jay Nolan Camp?

- ❑ **Friend**
- ❑ **Newspaper/Magazine**
- ❑ **Conference**
- ❑ **American Camp Association Directory**
- ❑ **Previous Attendance**
- ❑ **Regional Center**
- ❑ **Online (we'd love to know where you found us!)** _____
- ❑ **Other:**_____

Tee Shirt Size_____
Standard tee shirts are available in Youth S,M,L and Adult S, M, L, XL, 2XL.
Please specify Youth or Adult.

Payment Method:

- ❑ **Check enclosed**
- ❑ **Credit Card**
- ❑ **Regional Center**

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PAYMENT SCHEDULE FOR ALL CAMPERS

Application and payment must be sent together and by the dates that follow to receive the specific rate.

	Dec. 1-Feb. 29	Mar. 1-May 31	June 1- July 1
Campers with a disability	**$1200**	$1250	$1300
Campers without a disability	**$1200**	$1250	$1300

Down Payment - **$300.00** (due with application)

Jay Nolan Community Services, Inc. reserves the right to review and discuss individual needs for support and supervision, which may result in an increased rate.

CANCELLATION POLICY

Payment in full is required at the time of registration. If you need to cancel for any reason, we must receive written notice of cancellation (either mailed or faxed) by **May 31, 2025**. Your registration payment will be refunded less a $50.00 service charge.

Cancellations after that time and 'No-Shows' are non-refundable.

Method of Payment:

_____ Check – Made out to:
Jay Nolan Community Services, Inc.
_____ Cash
_____ Visa
_____ Mastercard
_____ American Express
_____ Online (PayPal)

PLEASE PRINT

Date

Name on Card

Billing Address

City/State/Zip

Phone

Email

AMOUNT:

$_____ Camp Payment

$_____ Donation to help support Jay Nolan Camp

$_____ Total enclosed or to be charged

Credit Card # _____ Exp. date

Authorized Signature

PARENT(S)/ CAREGIVER(S) CONTACT INFORMATION:

Name_____**Relationship**_____
First Last
Address (if different from Child's)_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

Name_____**Relationship**_____
First Last
Address (if different from Child's)_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

EMERGENCY CONTACT INFORMATION: (Different than Parent)

Name_____**Relationship**_____
First Last
Address_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

I give permission to Jay Nolan Community Services, Inc. to allow my child to participate to the best of their ability in a residential camping program including but not limited to these activities,: Archery, Sports & Games, Swimming, Hiking, Rock Climbing Wall, Arts & Crafts, Camp Dance, Talent Show, etc.

Name_____**Relationship**_____
First **Last**

Signature_____**Date**_____

Is there anyone this child would like to bunk with, in the same cabin? (They must be the same gender, and within <u>at least</u> one year of each other). This request will be considered and honored when/if possible. (No guarantees are made.)

Name_____ **Relationship**_____
First **Last**

Name_____ **Relationship**_____
First **Last**

SLEEP PATTERN/ ROUTINE *(Check all that apply)*:

- ❑ **Sleeps throughout the night**
- ❑ **Restless**
- ❑ **Will wake up throughout the night**
- ❑ **Usually uses the bathroom sometime in the night**
- ❑ **Usually goes to bed early (before 8pm)**
- ❑ **Will want to go to bed late (after 10pm)**
- ❑ **Wakes up early (before 7am)**
- ❑ **Will want to wake up late (after 8am)**

Do you have any suggestions to make for a restful night's sleep for your child?

_____
_____

What are your child's favorite foods and/or dietary restrictions (if any)?

FAVORITE FOODS: _____

_____

_____

_____

_____

_____

DIETARY RESTRICTIONS*:

- ❑ **None**
- ❑ **Vegetarian**
- ❑ **Vegan***
- ❑ **Kosher /Halal***
- ❑ **No Dairy**
- ❑ **Gluten Free ***
- ❑ **No Sweets**
- ❑ **Nuts/Beans**

Other dietary restrictions: _____

_____

****Note: Some diets may require that the family send the necessary food/supplements.***

I give permission for the following first aid to be provided by authorized personnel if there is a need (Name brands are listed as examples only). *Check all products that you will permit:*

- ❑ **Sunscreen**
- ❑ **Antibiotic Ointment (Neosporin)**
- ❑ **Anti-Itch Cream/Spray (Caladryl)**
- ❑ **Non-Aspirin Pain Reliever (Tylenol)**
- ❑ **Antiseptic Wash (Betadyne, Peroxide)**
- ❑ **Insect Repellant (Off)**
- ❑ **Non-Prescription Antihistamine (Benadryl)**

Name_____ **Relationship**_____
First **Last**

Signature_____ **Date**_____

DIAGNOSIS:

- ❑ None
- ❑ Autism
- ❑ Asperger Syndrome
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Intellectual Disability
- ❑ Seizure Disorder
- ❑ Pica
- ❑ Prader Willi Syndrome
- ❑ ADD/ADHD
- ❑ Bipolar Disorder
- ❑ Chronic Illness:_____ _____
- ❑ Mental Health:_____ _____
- ❑ Other:_____

REQUIRING 1:1 SUPPORT:

- ❑ Does Not Apply
- ❑ Yes
- ❑ No
- ❑ Not Sure

COMMUNICATION SKILLS:

- ❑ Verbal
- ❑ Non-Verbal
- ❑ Limited Verbal Skills
- ❑ Uses Sign Language
- ❑ Uses Facilitated Communication Devices
- ❑ Other:_____

SCHOOL:

Does your child have an IEP for school? Yes___No___
Last grade completed_____
Type of school/program your child participates in:
_____
_____
_____

Regional Center: _____ UCI#_____ Service Coor. Name _____
Service Coor. email _____

SELF-SUFFICIENCY:

Does your child require assistance with the following? *(Check those that apply)*

❑ **Showering** ❑ **Toileting** ❑ **Dressing** ❑ **Eating**

If so, what type of assistance do they require?

❑ **Verbal Prompts** ❑ **Hand-over-hand** ❑ **Complete Assistance**

Please provide additional information:_____
_____
_____
_____
_____
_____
_____
_____
_____

Please select your camper's favorite activities or interest (any that apply):

- ❑ Archery
- ❑ Swimming
- ❑ Group Sports
- ❑ Hiking
- ❑ Rock Climbing Wall
- ❑ Scavenger Hunts
- ❑ Costume Play/Dress Up
- ❑ Acting/Singing/Performing
- ❑ Craft Activities
- ❑ Drawing/Painting
- ❑ Geology/Earth Science
- ❑ Plant/Animal Identification
- ❑ Community Service
- ❑ Activity/Event Planning
- ❑ Advocacy/Social Justice
- ❑ Leadership
- ❑ Environmentalism/Ecology
- ❑ Play in Nature

OVERALL NATURE (BEHAVIOR/ ATTITUDE):
Please make us aware of any potential behaviors to possibly expect....

- ❑ Good-natured
- ❑ Withdrawn/ Shy
- ❑ Self-Injurious
- ❑ Aggressive
- ❑ Wandering
- ❑ Running
- ❑ Tantrums
- ❑ Property Destruction
- ❑ Excessive Verbalization
- ❑ Perseveration
- ❑ Frustration when working on tasks
- ❑ Other: _____

Please explain what we will need to know, about any checked behaviors and their frequency:

_____
_____
_____
_____
_____

HOW SHOULD WE SUPPORT YOUR CHILD DURING CHALLENGING TIMES?

- ❑ Separate from group
- ❑ Reason with
- ❑ Give extra attention
- ❑ Other _____

Please explain what helps your child cool down after challenging moments?
(Music, books, walks, conversation, etc…)

_____
_____

Please explain anything else (or provide more specific information) we need to know in order for your child to have a successful time at Camp (Attach additional pages, if necessary):

_____
_____
_____
_____
_____

This information assists us in applying and for grants/additional funding:

PLEASE CHECK ONE BOX:

	African American	American Indian	Asian	Caucasian	Hispanic	Pacific Islander	Other:
Male							
Female							
Other							

I GIVE MY PERMISSION FOR THE CAMP HEALTH CARE PROVIDER/ AUTHORIZED CAMP STAFF TO ADMINISTER MEDICATION
AND PROVIDE ROUTINE HEALTH CARE (AS MAY BE NECESSARY).

Jay Nolan Community Services (JNCS) isa Covered Entity under HIPAA (the Health Insurance Portability and Accountability Act). to the extent JNCS receives private health/medical information about any of its' clients; JNCS will treat that information as private and comply with applicable privacy laws.

Name_____ **Relationship**_____
First **Last**

Signature_____ **Date**_____

HEALTH AND IMMUNIZATION HISTORY

1. Is Camper covered by Medi-Cal? YES_____NO_____MediCal #_____

2. Is Camper covered by private medical insurance? YES_____NO_____

Medical Insurance_____ Policy #_____

Group #_____Name of Primary Insured_____

ALLERGIES - *List all known.* **REACTION - describe reaction and management of the reaction**

Medication Allergies (list)- include aspirin, penicillin, etc.

_____ _____

_____ _____

Food Allergies (list)- include specific foods, dyes, etc.

_____ _____

_____ _____

Other Allergies (list)- include insect stings, hay fever, asthma, pollen, etc.

_____ _____

_____ _____

GENERAL QUESTIONS: (Explain 'Yes' answers below.)

HAS/DOES THE PARTICPANT:	YES	NO	HAS/DOES THE PARTICIPANT:	YES	NO
Had a recent injury/illness/infectious disease?			Ever had a problem with joints?		
Ever had a chronic/recurring illness/condition?			Have skin problems (itching, rash, acne)?		
Ever been hospitalized?			Have diabetes?		
Ever had surgery?			Have asthma?		
Have frequent colds/headaches?			Had bowel problems (diarrhea, constipation)?		
Had psychiatric/psychological counseling?			Ever had a head injury?		
Had psychiatric/psychological hospitalization?			Have problems with sleepwalking?		
Wear glasses, contacts, or protective eyewear?			If female, have menstrual problems?		
Ever had frequent ear infections?			Have a history of bed-wetting?		
Ever passed out during/after exercise?			Have bladder problems?		
Ever had chest pain during/after exercise?			Ever had an eating disorder?		
Ever had high blood pressure?			Ever had sinus problems?		
Ever had a heart murmur or heart disease?			Other?		
Ever had back problems?			**Been looking forward to camp?**		

Please explain 'Yes' answers:_____

_____

_____

Which of the following has the participant had?

- ❑ **Measles**
- ❑ **Chicken Pox**
- ❑ **Rubella**
- ❑ **Mumps**
- ❑ **Hepatitis A**
- ❑ **Hepatitis B**
- ❑ **Hepatitis C**

TB Mantoux Test
Date of last test_____
Result *(Check)*:
Positive Negative

ATTACH A COPY OF IMMUNIZATION RECORD, OR write in all dates for:

VACCINE:	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DTP						
TD (tetanus/diphtheria)						
TETANUS						
POLIO						
MMR						
or Measles						
or Mumps						
or Rubella						
Homophiles influenza B						
Hepatitis B						
Varicella (chicken pox)						

JAYNOLAN recreational services Summer Camp

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AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT

____ I, the person named below, consent to medical treatment.

____ I am a parent, guardian or conservator, or person authorized under California or United States Law or by court order, to authorize consent to medical treatment for the person named below.

Name of Person: _____

I authorize Jay Nolan Community Services Inc., any of its employees, agents or contractors to obtain and consent to medical assistance and treatment, including but not limited to: surgery, dental treatment, mental health treatment, and anesthesia, for the person named above. In granting this authorization, I understand as follows:

- That Jay Nolan Community Services Inc. may release information regarding the person's medical history to secure medical assistance or treatment,
- That Jay Nolan Community Services Inc. may provide medical assistance and treatment to the person if other appropriate medical assistance and treatment cannot reasonably be obtained when needed,
- That Jay Nolan Community Services Inc. will make all reasonable efforts to secure medical assistance and treatment with professionally accepted standards for the area where the person is located (not necessarily the place of residence) when treatment is sought,
- That Jay Nolan Community Services Inc. and any of its employees, agents and contractors will make all reasonable efforts to contact me as soon as possible in the event of a medical emergency,
- That Jay Nolan Community Services Inc. carries liability insurance only. I agree that all medical or hospital costs incurred are my sole responsibility.
- That if I have any objections or limitations to treatment, I have them listed below:
  _____
  _____
- That I may terminate this authorization at any time by written notice to the Executive Director of Jay Nolan Community Services. Unless I terminate in this manner, this authorization shall remain in effect for one (1) year after the date signed.

Signature:_____ Date:____/____/____ Relationship:_____

Witness:_____ Date:____/____/____

CONSENTMED, REV2, 12/03

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Public Relations Consent Form

The purpose of this form is to give Jay Nolan Community Services, Inc. permission to use photographs and other likenesses of employees, volunteers, people served, and others who may grant permission for the promotion of the agency's programs, its mission, and general community outreach. Public relations/marketing activities may include, but are not limited to: publication of photographs in newsletters, on the web site, in advertisements, in brochures, on flyers, on display boards, on television, or in video and slide presentations.

NAME_____

I(We), _____, being either of legal age to consent, or the legal parent(s), guardian(s), or conservator(s) of the above named individual who is a minor child or person unable to consent on his or her own behalf, give Jay Nolan Community Services, Inc. (JNCS), its assigns, or successors, the right to use the above named individual's name and any photograph, video, voice recording or any other likeness JNCS has in any media form, now known and hereafter created, for the purpose of promoting JNCS mission, products, services, or programs. JNCS also has the right to substitute the above named individual's voice if it is deemed proper by JNCS.

Furthermore, I(We) agree that such items shall belong to JNCS and remain free and clear of any claim whatsoever on my(our) part or the part of the above named individual.

I(We) understand that I(We) may terminate authorization at any time for any future photographs, video, voice recordings, or other likenesses produced of the above named individual by delivering written notice to the Executive Director of JNCS. However, said termination shall not cover items previously authorized and already in production/use.

_____
(Signature of Consenting Adult/Parent/Guardian)

_____
(Printed Name) (Date)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Witness) (Date)

Participant's Name: _____
Print Name

Lions Camp at Teresita Pines & Lions Camp at Wrightwood

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in the Lions Camp at Teresita Pines Rock Climbing Wall (herein after known as "LCTP Rock Wall"), on **7/28/2024** through **8/2/2024** I, for myself, my heirs, personal represen tatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** Lions Camp at Teresita Pines, its officers , employees, volunteers and agents from liability **from any and all claims including the negligence of Lions Camp at Teresita Pines, its officers, employees, volunteers and agents,** resulting in personal injury, accidents or illn esses (including death), and property loss arising from, but not limited to, participation in the LCTP Rock Wall activities.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Assumption of Risks: Participation in the LCTP Rock Wall activities carries with it certain inherent risks that cannot be eli minated regardless of he care taken to avoid injuries. The specific risks vary from one activity to another, but the risks ran ge from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint o r back injuries, heart attacks, and concussions 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the activities made possible by the LCTP Rock Wall. I hereby assert that my participation is voluntary and that I knowin gly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD the **Lions Camp at Teresita Pines** HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney' s fees brought as a result of my involvement in the LCTP Rock Wall activities and to reimburse them for anysuch expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is in tended to be as broa and inclusive as is permitted by the law of the State of California and that if any portion thereof is he ld invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Participant's Age (if minor) _____

Revised 6/2011

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2025 MEDICAL EXAMINATION FORM- PAGE 1

A LICENSED PHYSICIAN MUST COMPLETE THE MEDICAL EXAMINATION FORM.

A MEDICAL EXAMINATION MUST BE PERFORMED WITHIN A YEAR PRIOR TO CAMP ATTENDANCE.

PLEASE COMPLETE BOTH PAGES.

Camper Information

Name:	**Sex:**	**Age:**	**Birthdate:**
Diagnosis or Disability (if applicable):			
BP:	**Height:**	**Weight:**	
Does Camper have a history of seizures? Yes ☐ No ☐			
If yes, specific type:			
Frequency:	**Length:**		
Present Status:	**Date of last seizure:**		

MEDICATIONS (To be administered at Camp)*

If camper is taking herbal/homeopathic medications, vitamins, or over-the-counter medications, they also must be listed. If a psychiatrist prescribes medications, they must complete a form listing medications as well. Attach additional pages, if necessary.

***Please Print Legibly**

Name of prescription medication, vitamins, homeopathic/herbal medications, over-the-counter medications	Dosage	Purpose	Times to be administered (Camp mealtimes/bedtime listed):				
			B-fast 8:30am	Lunch 12:30pm	Dinner 5:30pm	Bedtime 9:00pm	Other ?
1.							
2.							
3.							
4.							
5.							
6.							
7.							

Health Care Providers at camp follow standing orders from our physician consultant, which include over-the-counter medications as needed, such as analgesics, topical ointments, decongestants, and medications for colds, allergies, indigestion, constipation, diarrhea, eye and mouth care, and basic first aid. Are there any concerns with administration of over-the-counter medications and/or treatments?

Yes ☐ No ☐

If yes, explain_____

X_____ **(OVER)** _____

Signature of Physician **Date**

JAYNOLAN recreational services Summer Camp

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2025 MEDICAL EXAMINATION FORM – PAGE 2

Camper's Name_____

DESCRIPTION OF JAY NOLAN CAMP FOR PHYSICIAN'S REVIEW

Jay Nolan Camp is an inclusive sleep-away camp that runs 6 days/5 nights each camp session in the mountains of Wrightwood, CA. The elevation is approximately 6,000 ft and the terrain of the campground can be uneven in certain areas. All activities are non-competitive and carefully supervised (including Archery, Sports & Games, Swimming, Hiking, etc.). They are designed to meet the needs of all children, encouraging their participation to the best of their ability. Camp Staff/ On-site Health Care Provider will strictly observe physician recommendations.

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp_____

_____

_____

Any medically prescribed meal plan or dietary restrictions_____

_____

_____

Description of any limitation or restrictions at camp_____

_____

_____

Additional information for health care staff at camp_____

_____

_____

HEALTH STATEMENT

I hereby certify that the above camper _____is _____is not in good health and physically able to attend camp. The camper has no evidence of a skin rash or communicable ailment that might endanger the health of other people. The camper has had no recent illnesses with the exception of:_____

Signature of Physician	**Date of Exam**	**Date of Form Completion**

Name of Physician	**Physician's Address**

Name of Medical Agency if Camper attends a Clinic or Hospital	**Telephone No.**	**Fax No.**