

Silver Towers Application - 2024



Please review the schedule for 2024 carefully when choosing your preferred sessions. Campers will be placed on a first come, first serve basis with those returning completed paperwork being placed in their preferred session. Each week we can accommodate up to 60 campers.

Camp will close at the end of each Session to be deep cleaned. No exceptions to this policy. This does prevent any camper from staying more than two weeks in a row.

No camper will be able to stay overnight between sessions this year. Each session will consist of two weeks. If a camper is coming for two weeks in one session, they will be able to stay over on the Saturday night between weeks.

Please send in your applications as soon as possible to ensure the weeks you are looking for.

_____ 1. **Fully Completed Camper Application.**

_____ 2. **Nonrefundable Application Fee of \$25. Checks should be made payable to: Silver Towers Camp. Please DO NOT send checks written to Carolyn Ravenna.**

_____ 3. **Completed Physical Form**. The physical/medication list has changed. Please read that carefully. Any medication changes occurring prior to the camper's session, new orders must be sent in prior to check in. This allows for a smooth check in process.

NO CAMPER WILL BE ALLOWED TO STAY AT SILVER TOWERS WITHOUT COMPLETE and SIGNED ORDERS FROM THE PHYSICIAN AS WELL AS ALL MEDICATIONS IN THEIR ORIGINAL PACKAGING.

Mail completed application and fee (Checks made payable to Silver Towers Camp) to:
Carolyn Ravenna, Director
241 Lincoln Avenue
Rutland, VT 05701

The cost of tuition is \$600.00. *A non-refundable fee of \$25.00 must accompany the application. The remaining payment is due before your camper arrives to camp.**

Please arrange for payments as no camper will be allowed to attend until payment is made in full.

The camp will not bill ARIS for you. This is your responsibility. **PLEASE DO THIS AS SOON AS YOU RECEIVE THE INVOICE.** Please contact me directly at 802-345-4209 with questions.

***Some partial scholarships may be available by contacting Carolyn Ravenna directly.

Silver Towers Camp 2024

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Name: _____ Date of Birth _____ Age _____ Sex M _____ F _____
 Email Address: _____ Phone # () _____
 Home Address _____ City _____ St. _____ Zip _____
 Mailing Address _____ City _____ St. _____ Zip _____

Names of persons to be contacted in case of emergency.
Phone numbers must be current of someone who will be able to help in case of an Emergency.

Home Provider or Care Giver _____ Phone # () _____
 Address _____ City _____ St. _____ Zip _____
 Parents or Legal Guardian _____ Phone # () _____
 Address _____ City _____ St. _____ Zip _____
 Additional Contact in Case of Emergency: _____ Phone # _____

Health Insurance Coverage

Is the Camper covered by family medical/ hospital insurance? Yes _____ No _____
 Medicare # _____ Medicaid # _____
 Photocopy of front and back of health insurance card must be attached to this form as well as COVID-19 vaccination records.

This section must be completed by the parent/guardian for camper's attendance.

Permission to Provide necessary Treatment or Emergency Care: I hereby give permission for medical personnel selected to order and approve various medical/treatment; to release any records necessary for insurance purposes; to provide/arrange necessary transportation for the Camper in the event I cannot be reached in an emergency. I hereby give permission to the medical personnel to secure and administer treatment, including hospitalization for the person named above. I agree to abide by the restrictions as specified above during camp.

Signature and Printed Name of Parent/Guardian or Adult Camper

NEW SESSIONS SCHEDULE, PLEASE REVIEW CAREFULLY

There will Not be any overnights between Sessions.

Session 1: _____ Week 1: June 23 – June 29 (ages 31-70)
 _____ Week 2: June 30 – July 6 (ages 31 – 70) (**No Overnight 7/6**)
 Session 2: _____ Week 3: July 7 – July 13 (ages 31 – 70)
 _____ Week 4: July 14 – July 20 (ages 31 – 70) (**No Overnight 7/20**)
 Session 3: _____ Week 5: July 21 – July 27 (ages 31 – 65)
 _____ Week 6: July 28 – Aug. 3 (ages 31 – 65) (**No Overnight 8/3**)
 Session 4: _____ Week 7: Aug. 4 – Aug. 10 (ages 15 – 30)
 _____ Week 8: Aug. 11 – Aug. 17 (ages 15 – 30) (**Camp Ends 8/17**)

Special Diet Instructions:

We have many campers with special diets. We will do everything in our power to modify these diets to the best of our abilities. If your camper has an Allergy to a specific food, that is important to us. If your camper is a picky eater, we will do our best to make sure they eat. PLEASE DO NOT SEND YOUR CAMPER TO CAMP WITH BAGS OF SNACKS, CANDY or SODA.

Please read this section and check all that apply:

Chopped _____ Pureed _____ Food Moistened _____
 Meat Cut Small _____ All Food Cut Small _____
 Lactose Intolerant _____ Gluten Free _____ Specific Food Allergy _____
 Please list here: _____

What best describes Camper's vision?

___ Wears Glasses ___ Normal Vision ___ Has Functional Vision
 ___ Is Legally Blind ___ Blind

How does Camper communicate with others? ___ Uses Speech ___ Understands Speech

___ Uses Sign Language ___ Understands Sign ___ Uses Adaptive Communication Device

What is the best way to communicate with Camper if they are non-verbal?**Camper's Hearing**

___ Has Normal Hearing ___ Has Functional Hearing
 ___ Is Hard of Hearing ___ Is Deaf

Behavioral Challenges:

Indicate those that best describe the Camper in the last 5 years:

___ Aggression toward people ___ Tantrums ___ Self-Injury ___ Hyperactive
 ___ Aggression toward objects ___ Manipulative ___ Swears ___ Poor Peer Relations
 ___ Inappropriate Sexual Behavior ___ Withdrawn ___ Non-Compliance

If you checked any of the above please explain or attach documentation in regards to the Challenge: We reserve the right to deny the application if we feel this camper may be a threat to others or them self. We will not accept the Camper without documentation of Plans in place. Use additional paper if needed.

Other Challenges not listed: _____

What is the most effective way to deal with Camper's Behavioral Challenges? _____

Describe Campers Daily Living Skills: Campers must be self-sufficient in these areas needing minimal assistance from counselors: Please circle one of the following and explain if necessary.

Toileting	Independent	Needs Assistance	_____
Eating	Independent	Needs Assistance	_____
Hygiene	Independent	Needs Assistance	_____
Dressing	Independent	Needs Assistance	_____
Bathing	Independent	Needs Assistance	_____

Does the Camper Wet the Bed?: YES or NO If YES, how often? _____.
We have limited laundry facility. You will need to provide extra bedding, night time pull ups, padding for bed, laundry soap, etc.

Please use this space to provide any further information that will help us better serve your Campers Daily Living Skills NEEDS:

Camper's Physical Challenges

☐ Cerebral Palsy ☐ Spina Bifida ☐ Muscular Dystrophy ☐ Quadriplegic
☐ Paraplegia ☐ Ambulatory ☐ Uses Wheelchair ☐ Uses Crutches
☐ Walks with assistance ☐ Other: Please explain:

Camper's Intellectual / Cognitive Challenges

☐ Developmentally Delayed ☐ Mild ☐ Moderate ☐ Severe
☐ Autism Spectrum Disorder ☐ Mild ☐ Moderate ☐ Severe
☐ Emotionally Behaviorally Disturbed ☐ Mild ☐ Moderate ☐ Severe
☐ Down Syndrome ☐ Mild ☐ Moderate ☐ Severe

Other diagnosis if not listed above: _____

History of physical, mental, or sexual abuse which may have an impact on the Campers experience at camp:

Does this Camper have one to one support on a daily basis? YES or NO IF yes, then you must get approval to bring a one to one support person to Silver Towers. Notify us as soon as possible. We will not be able to provide one to one support while at camp. This year will be very different as we open up after two years.

MUST BE SIGNED BY PHYSICIAN BEFORE SUBMISSION

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PHYSICAL Form for Silver Towers Camp 2024

This must be completed by a certified and licensed physicians, (MD, DO), nurse practitioners, or physician assistants.

This form must be completed, signed and returned one month prior to camper's session. The physical and medication forms are only good for one year. Please note: Every camper must use this NEW FORM for 2024 attendance.

Camper's Name: _____ Date of Birth: _____

HEALTH HISTORY and CAMP PHYSICAL

Has the camper ever been diagnosed with or experienced any of the following conditions? Please circle Yes or No.

Loss of Consciousness No Yes	High Blood Pressure No Yes	Stroke/TIA No Yes
Dizziness during or after exercise No Yes	High Cholesterol No Yes	Concussions No Yes
Headache during or after exercise No Yes	Abdominal/Stomach problems No Yes	Asthma No Yes
Chest pain during or after exercise No Yes	Digestive Problems No Yes	Diabetes No Yes
Shortness of breath during or after exercise No Yes	Enlarged Spleen No Yes	Hepatitis No Yes
Irregular, racing or skipped heart beats No Yes	Urinary Discomfort No Yes	Single Kidney No Yes
Congenital Heart Defect No Yes	Osteoporosis No Yes	Spina Bifida No Yes
Heart Attack No Yes	Osteopenia No Yes	Arthritis No Yes
Cardiomyopathy No Yes	Sickle Cell Disease No Yes	Heat Illness No Yes
Heart Valve Disease No Yes	Constipation problems No Yes	Broken Bones No Yes
Heart Murmur No Yes	Easy Bleeding No Yes	Dislocated Joints No Yes
Endocarditis No Yes	Runs a normal temperature No Yes	

If you answer Yes to any of the following, please provide additional information.

Difficulty controlling bowels or bladder **No Yes** _____

Any past broken bones or dislocated joints: **No Yes** _____

Numbness or tingling in legs, arms, hands or feet **No Yes** _____

Weakness in legs, arms, hands or feet **No Yes** _____

Epilepsy or any type of seizure disorder **No Yes** list type and last seizure: _____

Pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet **No Yes** _____

Self-injurious behavior during the past year **No Yes** _____

Aggressive behavior during the past year **No Yes** _____

Depression (diagnosed) **No Yes** _____

Anxiety (diagnosed) **No Yes** _____

Describe any additional health or mental health concerns: _____

List surgeries and hospitalizations within the last three years: _____

- Date of Camp Physical Exam: _____ Date of Last Tetanus vaccination: _____
- Date and proof of all COVID – 19 Vaccinations and Booster: _____
- Camper's Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____
- O₂ Sat: _____ Temperature: _____
- **Indicate if abnormal:**
____ Head ____ Eyes ____ Ears ____ Abdomen ____ Genitalia ____ Nose ____ Lungs ____ Heart ____ Mouth ____ Extremities ____ Neurological

Please List Any Allergies:

Certification of Participation must be signed by checked off by campers Physician.

____ I certify that I have reviewed the Health History and examined this person and find no contradictions for participation in camp experience.

____ I certify that I have reviewed the Health History and examined this person and find they may participate in camp activities with the following restrictions (please list):

Physician's Signature: _____

Camp Physical Date: _____

Physician's Name (please print) _____

Phone & Fax #: _____

MUST BE SIGNED BY PHYSICIAN BEFORE SUBMISSION**2024 Medications to be dispensed while attending Silver Towers Camp:**

Campers Name: _____ DOB _____

Please have your physician fill out this entire form and sign it. We need a signature on Both pages of this physical/medication form. If there is a medication change by the time the camper comes to camp, new signed orders must be sent to camp prior to check in. If your camper uses an epi-pen or diastat or has a specific allergy or seizure plan, please make sure that you attach the signed allergy or seizure plan.

If the camper has trouble taking medications, please list the best way to administer medicine. _____

1. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
2. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
3. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
4. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
5. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
6. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
7. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
8. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
9. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
10. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
11. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
12. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____
13. Medication _____ Dosage _____ Times taken _____
Reason for taking _____
Prescribing Physician _____ Phone _____

Physician's Signature: _____ Date: _____

Physician's Name (please print) _____ Phone & Fax #: _____

IMPORTANT UPDATED MEDICAL INFORMATION

A camper must have a current Physical and Medication list to attend camp. The Physical, Medication list and the Over the Counter Medication list must be filled out on the Silver Towers Physical Form 2024. All Physical and medication orders are only good for one year. Please be aware if the Physical will expire prior to attending camp or during the campers stay and you are not able to schedule a Physical until after their selected week you must pick a different week. No exceptions will be made. We encourage you to call your campers Physicians and ask when their last Physical was and schedule their next Physical so that you will not run into any problems this summer with expired Physicals. If you are not able to fit all medications on MEDICAL FORM please continue list onto a separate piece of paper. **That paper will also need to be signed by Health Care Provider. If you provide a print out of medications, that form will also need to be signed.** If your camper takes over the counter medications (examples: Calcium, Vitamins, Allergy medications, sleep aids, fiber, antacids, bowel medications, pain relievers) in addition to the medications his/her Physician prescribes the Physician will need to sign off on those medications.

It is very important that you take the time to carefully review the medication list with the Physician. Please make sure the list matches what is on the prescription bottle and the way you administer medication at home is consistent with what is on the prescription bottle.

If there are discrepancies at check in with the medication list the Physician provides and the medications brought to camp, your camper will not be allowed to check-in.

Please note if there is additional information required, it will be your responsibility to get this information from your campers Physician and send it to Silver Towers. The nursing staff is extremely busy and should not have to track down this information for you. If you have any questions, please call us so we can make sure the proper documentation is provided for a smooth check in when you and your camper arrive. We will continue to limit the number of people at check in this summer. Please be respectful of the check in time you are assigned.

We will also do a Covid test on each camper when they arrive to Silver Towers which will take place before they meet with the nursing staff to complete the check in process. Do Not go directly to the Nurse Check-in before meeting with the Check-In Staff.

If a camper shows any signs of COVID – 19, we will test them and ask that they be picked up immediately by parent, guardian or caregiver.

We are mandating mask wearing during check-in by all campers and those bringing the camper to camp. We know this may be difficult however we are doing our best to reduce the spread of COVID-19 at Silver Towers.

See back of this form for Over the Counter Medication Permission.

Silver Towers Health Staff

PERMISSION FOR OVER THE COUNTER MEDICATIONS

(To be filled out and signed by parents, home providers, guardians or physicians)

Please check any medications that your camper CAN be given if they are sick or injured at camp:

The following medications (or their generic equivalents) **May** be stocked in the camp Health Center and administered as needed. If your camper takes any of these on a regular basis they must be provided by you/camper with a Physician's order stating that the camper takes this medication on a regular basis. This will allow our nursing staff to administer the over the counter medications as no oral medication of any kind may be kept in the dorm by campers or counselors.

Persistent conditions or those needing a physician's care will be referred to the parent/guardian. We will require you or a caregiver to come to camp and take the camper home or to any medical center to be evaluated. Reentry to camp will be determined by the Nursing Staff at Silver Towers Camp.

- | | |
|--|--|
| <input type="checkbox"/> Sunburn relief spray/cream (Solarcaine, Bactine, Aloe Vera) | <input type="checkbox"/> Ibuprofen (Advil) |
| <input type="checkbox"/> Antiseptic ointments (Bacitracin, Neosporin) | <input type="checkbox"/> Acetaminophen (Tylenol) |
| <input type="checkbox"/> Naproxen (Aleve) | <input type="checkbox"/> Loratadine (Claritin) |
| <input type="checkbox"/> Cough Drops / throat lozenges | <input type="checkbox"/> Cough syrup (Robitussin DM) |
| <input type="checkbox"/> Decongestant (Sudafed) | <input type="checkbox"/> Antihistamine (Benadryl) |
| <input type="checkbox"/> Sore throat spray (Chloraseptic) | <input type="checkbox"/> Burn Gel (Aloe Vera) |
| <input type="checkbox"/> Milk of Magnesia (for constipation) | <input type="checkbox"/> Antacids (Tums, Maalox) |
| <input type="checkbox"/> Anti-Diarrheal (Kaopectate, Imodium AD) | <input type="checkbox"/> Pepto Bismal |
| <input type="checkbox"/> Sting-Ease (for insect bites) | <input type="checkbox"/> Stool Softener |
| <input type="checkbox"/> Calamine/Caladryl Lotion (for insect bites, poison ivy, etc.) | <input type="checkbox"/> Hydrocortisone cream (rash, bug bites) |
| <input type="checkbox"/> A & D Ointment (skin protectant) | <input type="checkbox"/> Glucose (for diabetic emergency) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Eye Rinse (eye irritation) |
| <input type="checkbox"/> Antiseptic Wound wash (minor cuts, scrapes, etc.) | <input type="checkbox"/> Hydrogen Peroxide (minor cuts, scrapes) |

OTHER

If your camper has a known allergy and carries an Epi-pen on a regular basis that must come to camp in the original prescription box with an Order from the prescribing physician.

Please be aware that if your camper experiences an undiagnosed life threatening allergic reaction, nursing staff will treat the camper as needed with an Epinephrine (EPI-pen) and 911 will be called. Please make staff aware if your camper has a known allergy to Epinephrine.

Camper's Name: _____
(Please Print)

Date of Birth: _____

Parent/Guardian/Home Provider Name: _____ Phone #: _____
(Please Print)

Parent/Guardian Home Provider's Signature _____ Date _____