



Adventure Weekend

"What type of aphasia is camp designed to address?"

ACNW was created to serve adults with sudden onset aphasia due to stroke and other brain injuries. Our current programs are not designed for individuals with primary progressive aphasia (PPA); however, we hope to expand to include them and their caregivers in the future. ACNW is not designed for persons with dysarthria.

2018 CAMP APPLICATION

Registration is available on a first-come-first-serve-basis, based on availability of appropriate accommodations and space.

Name of person with aphasia (Camper): _____

☐ Male ☐ Female Date of birth: ____/____/____ Month & Year of aphasia diagnosis: ____/____

Address: _____

Telephone Number: _____ Email address: _____

Care Partner who will be accompanying you: _____ Relationship: _____

Address (if different): _____

Telephone Number: _____ Email address: _____

Will any additional family members be attending with you? ☐ Yes (please list below) ☐ No

<u>Name</u>	<u>Relationship</u>	<u>Telephone Number</u>
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_____	_____	_____
_____	_____	_____

<u>Emergency Contact Person & Relationship</u>	<u>Telephone Number</u>
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_____	_____
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☐ **Weekend Camp (August 24th, 25th & 26th)** Number of people ____ x \$195 per person = \$_____

There are a limited number of parking spaces for campers (no electrical). Would you like to camp? ☐ Yes

☐ **Saturday Day Camp (August 25th)** Number of people ____ x \$85 per person = \$_____

☐ We would like to REQUEST a partial scholarship to attend in the amount of \$_____

☐ We would like to DONATE to the scholarship fund. Amount enclosed: \$_____ (Thank you!)

Tshirts may be available for Camp this year. If they are, what size do you wear? Camper _____ Care partner _____

Please include camp registration full payment with this form unless you are requesting a partial scholarship.

Payment is non-refundable after August 8, 2018. Registration is not tax deductible.

Make checks payable to and mail this form to:

The Aphasia Network
PO Box 13406, Portland OR 97213

If you have additional questions, contact us at: (503) 577-1282 or Email: info@aphasianetwork.org

Independence and Assistance for campers:

Campers must be **independent or need only a minimum of assistance with:**

- Dressing & Grooming
- Transferring into & out of the lower bunk beds
- Mobility
- Toileting – *we cannot accommodate incontinence without the use of camper-provided protective garments and the need for a minimum of assistance*
- Eating

Campers are responsible for getting to and from camp. There is no bus service to camp.

Medical Support:

- Nurse on duty 24 hours a day. First aid is available. Vital signs can be monitored on a regular basis.
- Campers are responsible for taking personal prescription medications. **We do not administer medications.**
- Camp is approximately 13 miles from Tillamook Regional Medical Center.
- Most diet preferences/requirements can be accommodated.

Please read **the accompanying Professional Standards and Safety Policies** and **sign your consent:**

I have read and understood the Professional Standards and Safety Policies of The Aphasia Network and hereby agree to abide by the policies outlined in said documents. I am aware that my refusal to follow the policies may result in my discharge from Camp and preclude my participation from Aphasia Network events in the future. Note: Camp Magruder is a drug-free, weapons-free facility

Survivor: _____ Date: _____








Care Partner: _____ Date: _____

PHOTO & VIDEO RELEASE: I give my permission for Aphasia Camp Northwest and/or Pacific University staff, faculty or representatives to photograph, video and/or audio record me directly or incidentally throughout my time at Aphasia Camp Northwest Adventure Weekend. It is my understanding that photographs, video and/or audio recordings may be used for educational, research, and/or promotional purposes. These purposes may include but are not limited to presentations, publications, classroom instruction, marketing outreach (print and/or web media) and other educational, research and/or promotional purposes as determined by the parties listed ABOVE. I understand that if I do not want to be photographed, video and/or audiotaped and am inadvertently recorded, my image and/or audio recording will be removed from any media.

Camper: ☐ I agree (yes) ☐ I decline (no) Signature: _____ Date: _____

Care Partner: ☐ I agree (yes) ☐ I decline (no) Signature: _____ Date: _____

Do you use an **assistive device** for **mobility**, please mark all that apply below:





- ☐ **Cane**  ☐ Indoor ☐ Outdoors ☐ Chair to Chair ☐ to and from toilet
- ☐ **Walker**  ☐ Indoor ☐ Outdoors ☐ Chair to Chair ☐ to and from toilet
- ☐ **Wheelchair**  ☐ Indoor ☐ Outdoors ☐ Chair to Chair ☐ to and from toilet
- ☐ **Scooter**  ☐ Indoor ☐ Outdoors ☐ Chair to Chair ☐ to and from toilet
- ☐ **Person**  ☐ Indoor ☐ Outdoor ☐ Chair to Chair ☐ to and from toilet
- ☐ **Other:** _____ ☐ Indoor ☐ Outdoors ☐ Chair to Chair ☐ to and from toilet
- (Ex. Gait belts  or Slide boards )

Please indicate how **comfortable** you are **moving around**:







- Walking indoors:** ☐ Not good ☐ Kind of good ☐ Pretty good ☐ Very Good
- Walking outdoors:** ☐ Not good ☐ Kind of good ☐ Pretty good ☐ Very Good
- Using stairs:** ☐ Not good ☐ Kind of good ☐ Pretty good ☐ Very Good















When going to the **toilet**, do you use a:

			
raised toilet seat	commode	grab bars <input type="checkbox"/> left <input type="checkbox"/> right	catheter

COMMUNICATION

I have difficulty with	none	some	a lot
 <input type="checkbox"/> understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What **helps** you to **communicate**? Please **circle**.

 writing	 drawing	 communication book
 choices	 iPad or device	 camera
 family or friend	 extra time	 gesture
 pointing	 pictures	 maps
 speak slowly	<i>boating</i> key words	 quiet

DIETARY INFORMATION:

Do you **cough or choke** when eating or drinking? ☐ Yes ☐ No

Are you **comfortable eating or drinking** the following? (*Check all that apply*)

☐ **Hard/Dry/Crunchy foods**
Like Toast or Bacon



☐ **Soft foods**
Like Breads



☐ **Pureed foods**
Like Applesauce



☐ **Liquids**
Hot or Cold?



Are you following a **special diet**? Please check all that apply:

☐ **Anything** (*including meat, chicken, fish*)

☐ **Vegetarian**

☐ **Vegan**

☐ **Low sodium**

☐ **Diabetic**

☐ **Gluten Free**

☐ **Soft Diet** (*for chewing or swallowing issues*) ☐ chopped ☐ soft ☐ pureed

☐ **Thickened liquids** ☐ pudding thick ☐ honey thick ☐ nectar thick

☐ **Other** (please describe): _____

Do you have any **food allergies**? ☐ Yes ☐ No

Do **you use an EpiPen®**? ☐ Yes ☐ No

What are you allergic to? _____

Describe reaction? _____

Do you use an **alternate means for communication**? Please check all that apply:

☐ AAC Device

☐ iPad

☐ Communication Book

Will you bring it to camp? ☐ Yes ☐ No

If you **currently receive** any of the following **therapies**, please list your provider:

Speech therapist name: _____ Phone: _____

Occupational therapist name: _____ Phone: _____

Physical therapist name: _____ Phone: _____

Psychologists/counselor name: _____

If you attend a **support group**, please list the name and how often/when you attend: _____

Please tell us about your medical history and state. NAME _____

HEALTH INFORMATION

Please circle all that apply.



stroke



seizures



brain injury



headaches



difficulty swallowing

☐ need thickened liquids



difficulty with digestion



diabetes

☐ type 1 ☐ type 2
☐ low blood sugar

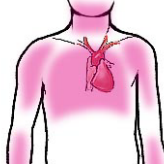


pregnant



blood pressure

☐ high ↑ ☐ low ↓



☐ angina
☐ heart attack

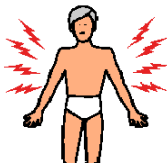


heart disease



difficulty seeing

☐ wear glasses



☐ chronic pain
☐ arthritis



☐ back pain
☐ other joint pain



☐ balance issues



difficulty hearing

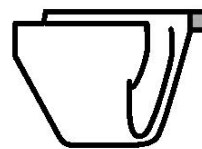
☐ wear hearing aid



Edema
(swelling)



☐ breathing problems
☐ asthma



☐ Incontinence
☐ use protective garments



bowel control problems

Please provide any other specific information about medical conditions or concerns: _____

Medications: *(Please attach a separate sheet if there is not enough room below)*

Name	Dosage	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any serious illnesses, sprains, broken bones or surgery of any kind in the past 12 months? If yes, please describe:

Other Allergies: Please identify and describe any other allergies (i.e. drugs, insect bites, etc.)

Allergic to	Nature of your Reaction
_____	_____
_____	_____
_____	_____

Do you use an epi pen for these? ☐ Yes (please bring it with you) ☐ No

IN CASE OF EMERGENCY CONTACT:

Name	Relationship	Day Phone	Night Phone
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Name	Relationship	Day Phone	Night Phone
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Please note that we are **unable** to provide **support** for some **medical conditions**. We will notify you in advance of Camp if your medical needs cannot be accommodated.

CAMPER (Person with Aphasia)

EMERGENCY MEDICAL AUTHORIZATION

*Complete Option 1 **OR** Option 2.* Parent or legal guardian must sign if participant is under 18.

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities including adventure course, except as noted.

OPTION 1 **AUTHORIZATION** FOR TREATMENT: I hereby give permission to the medical personnel onsite at Aphasia Camp Northwest to order X-rays, routine tests, treatment, and necessary transportation for the participant named above. In the event that the emergency contacts named above cannot be reached in an emergency, I hereby give permission to the onsite personnel to secure and administer treatment, including hospitalization, for the participant named above. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant.

Signature: _____ Date: _____

or

OPTION 2 **REFUSAL** TO CONSENT: I DO NOT give my consent for emergency medical treatment of this participant. In the event of illness or injury requiring emergency treatment, I wish the personnel onsite at Aphasia Camp Northwest to take no action or to: _____

Signature: _____ Date: _____

Care Partners – Please fill out this form with your information



Emergency Medical Authorization & Information

Note that any information you provide will be kept confidential, and shared only with Aphasia Camp NW representatives and, if necessary, emergency medical professionals.

Care Partner Name: _____ DOB: _____

Medical conditions:

____ Stroke ____ Brain Injury ____ Seizures ____ Headaches
____ Heart Disease ____ Angina ____ Heart Attack ____ Blood Pressure ☐ High ☐ Low
____ Pregnant ____ Asthma ____ Breathing problems ____ Difficulty Swallowing
____ Diabetes ____ Low blood sugar ____ Digestion Difficulty ____ Balance Issues
____ Incontinence ____ Use protective garments ____ Bowl control problems
____ Difficulty Hearing ____ Hearing Aid ____ Difficulty Seeing ____ Wear Glasses
____ Chronic Pain ____ Arthritis ____ Other joint concerns ____ Back pain ____ Edema

Please provide any other specific information about medical conditions you have:

Medications: *(Please attach a separate sheet if there is not enough room below)*

Name	Dosage	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any serious illnesses, sprains, broken bones or surgery of any kind in the past 12 months? If yes, please describe:

Are there any other medical concerns we should know about? If so, please describe:

Please describe any physical limitations you have (walking, climbing stairs, physical exertion). Describe what contributes to the limitation (e.g. debilitating back, knee, wearing leg braces, in a wheel chair, etc.)

Are you following a **special diet**? Please check all that apply:

☐ **Anything** ☐ **Vegetarian** ☐ **Vegan** ☐ **Low sodium** ☐ **Diabetic** ☐ **Gluten Free**

Allergies: FOOD ALLERGIES? ☐ Yes ☐ No If so, please describe: _____

Please identify and describe any other allergies (i.e. drugs, insect bites, dust, etc)

Allergic to

Nature of your Reaction

Do you use an epi pen ☐ Yes – Please bring with you ☐ No

IN CASE OF EMERGENCY CONTACT:

Name

Relationship

Day Phone

Night Phone

Name

Relationship

Day Phone

Night Phone

Please note that we are **unable** to provide **support** for some **medical conditions**. We will notify you in advance of Camp if your medical needs cannot be accommodated.

CARE PARTNER EMERGENCY MEDICAL AUTHORIZATION

Complete Option 1 or Option 2. Parent or legal guardian must sign if participant is under 18.

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities including adventure course, except as noted.

OPTION 1 **AUTHORIZATION** FOR TREATMENT: I hereby give permission to the medical personnel onsite at Aphasia Camp Northwest to order X-rays, routine tests, treatment, and necessary transportation for the participant named above. In the event that the emergency contacts named above cannot be reached in an emergency, I hereby give permission to the onsite personnel to secure and administer treatment, including hospitalization, for the participant named above. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant.

Signature: _____ Date: _____

or

OPTION 2 **REFUSAL** TO CONSENT: I DO NOT give my consent for emergency medical treatment of this participant. In the event of illness or injury requiring emergency treatment, I wish the personnel onsite at Aphasia Camp Northwest to take no action or to: _____

Signature: _____ Date: _____