



BlazeSports All-Star Camp Registration

BlazeSports All-Star Camp is an adaptive sports camp designed for kids/teens ages 7-17 with physical disabilities including spina bifida, spinal cord injury, cerebral palsy, visual impairment, amputation, dwarfism, acquired brain injury, muscular dystrophy or other related physical disabilities. Our summer camp offers a camper:staff ratio of 5:1

A limited number of summer camp scholarships are available. Please contact the Camp Director for eligibility information and how to apply.

All campers must be able to dress, bathe and use the restroom with little to no assistance. If they need total assistance with any of these categories, please discontinue registration. We will happily assist you in finding the right camp for your child. If you have any questions or concerns, please email youth@blazesports.org or call us at 404-270-2000.

Camper Contact Information

Name: _____ Nickname: _____
Gender: Male _____ Female _____ Date of Birth: _____
Address: _____
Primary Insurance Company: _____
Policy Holder: _____ Policy Number: _____

Parent/Guardian Information

Name: _____ Relation: _____
Phone Number: _____ Email: _____

Emergency Contact Info

Name: _____ Relationship: _____
Phone Number: _____

Medical Information

Primary Disability: _____
Details: _____
Secondary Disability (If applicable): _____
Details: _____
Allergies: List all known allergies, reactions and medications (if applicable) _____

Are all immunizations up to date? Yes _____ No _____ Date of last Tetanus shot: _____

- MMR, DPT/DI/Tdap, polio, varicella, Hep B, Meningococcal for 11-21 yo

If not, please specify which immunizations are currently not up to date? _____

Medications: SEE MEDICATION FORM

Please list any previous surgeries and date on which they performed:

Date: _____

Date: _____

Date: _____

History of seizures: Yes _____ No _____ If yes, give date of most recent: _____

History of heart disease, heart problems, or high blood pressure: Yes _____ No _____ If yes, please explain: _____

Has the camper ever had a brain injury or concussion? Yes: _____ No: _____ If yes, please give the approximate date and describe the incident. _____

Please list any camp activities from which the camper should be exempted due to health reasons: _____

Dietary Restrictions

List any food restriction (if applicable) _____

Personal Care/Independence

BlazeSports provides partial assistance in personal care. If the participants needs total assistance in any of these areas, please discontinue the registration process.

Check one for each category.

Dressing	Independent	Partial Assist	Total Assist
Eating	Independent	Partial Assist	Total Assist
Toileting	Independent	Partial Assist	Total Assist
Shower & Hygiene	Independent	Partial Assist	Total Assist
Bladder Control	Normal	Occasional	Incontinent
Bowel Control	Normal	Occasional	Incontinent

If partial assist please explain help needed: _____

Physical Concerns

Any concerns with pressure sores/skin breakdown? _____

Any concerns with muscle spasms/tightness? _____

Any concerns with temperature? _____

Extra sensitive to the sun? Yes _____ No _____

Describe hand grip: _____

Spinal Stabilization: Yes _____ No _____ If yes, location _____ Fusion or Fixed device _____

Shunt/catheters _____ Date of last revision _____

Type of Assistive Devices (% of usage):

Manual Wheelchair _____ Power Wheelchair _____ Orthotics _____

Crutches _____ Prosthetics _____

Campers with a Visual Impairment:

Amount of assistance needed for walking/running _____

Transfers

Check One

No assist	Partial assist	Total assist
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Endurance Level

Check One

Average	Fair	Poor
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Sport Skill Level

Check off the skill level your child has in the following sports.

Sport	Never Participated	Beginner	Intermediate	Advanced
Wheelchair basketball				
Track and Field				
Swimming				
Archery				
Rock Climbing				
Canoe/Kayak				

Name any other adaptive sport/recreation programs he/she has participated with:

Sport Track

Campers will have the opportunity to try every sport, but also get to choose a "sport track" where they can focus on their favorite sports and receive extra coaching.

Please put the following sports in order of your child's interest.

*1 being the top choice, 4 being the last choice.

Wheelchair Basketball	Track and Field	Swimming	Archery

Other Camper Information

T-shirt size:

YS	YM	YL	S	M	L	XL
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First time at sleep away camp: Yes _____ No _____

Child's ability to play and socialize with peers: _____

What are your goals for your child at camp? _____

What are your child's goals for camp? _____

If your child is upset, how should we help them? _____

Please mark how well your child stands in each category:

Follows Directions	Poor	Fair	Average
Attention To Task	Poor (0-1 min)	Fair (1-5 min)	Average (5min)
Frustration Tolerance	Poor	Fair	Average
Problem Solving	Poor	Fair	Average

Anything else we should know to help with a positive experience:

- Favorite subject: _____
- Hobbies: _____
- Favorite games: _____
- Something unique: _____

Anything we missed? _____

BlazeSports Camp - Camper Medication Form

Campers MUST bring enough medication for the entire duration of camp. The medical staff will store any medications needed during camp. Campers will NOT be allowed to give themselves any medications or have any medications in their cabins.

All medications should be in their original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

Due to the large amounts of medications given at camp, it is most efficient to give out medications at meal times. However, we understand this is not possible for all campers. If your child needs to be given a medication at a specific time, please list the time in the appropriate box (instead of choosing a meal time)

Camper Name: _____

Parent / Guardian Name: _____ Date: _____

Name of Medication	Day of Week Med is Given	Dose (mg) Amount to Give	Frequency	Check the Time Usually Given
<i>Example: Lasix</i>	<i>Everyday</i>	<i>20mg / 2 ml</i>	<i>2 Times a day</i>	Breakfast Lunch Dinner PRN
<i>Example: Penicillin</i>	<i>Mon, Wed, Fri</i>	<i>10mg / 1 tablet</i>	<i>1 Time a day</i>	Breakfast Lunch Dinner PRN
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Medication Form Continued

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