



SHADY OAKS CAMP

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2026 Shady Oaks Camp Camper Intake & Camper Care Sheet

Please complete this form and the attached Camper Care sheet with as much detail as possible. This information will help the staff care for your camper to the best possible standard. The information MUST be updated each year as Camper's needs do change. When you fill this in, please think about the instructions that you would give to someone new who would be caring for your Camper from the time your Camper wakes up in the morning until they are in bed at night. You can also send a video giving examples of how you care for your Camper (ie. feeding, positioning in wheelchair / bed, communicating, etc.) if you choose to do so. Please remember that we hire new staff every year, so there may be someone who has never worked with your Camper before.

1. Camper & Family Information

Camper Name: _____

Nickname: _____

Date of Birth: _____

Age: _____

Parent/Guardian Name(s):

Phone / Email / Preferred Contact: _____

Primary Diagnosis: _____

How did you hear about Shady Oaks Camp?

2. Camper Profile

Camper Strengths:

Challenges in Social or Camp Settings:

Family Goals for Camper's Camp Experience:

Camper Goal for camp experience

3. Eating & Oral Needs

Eats independently: Yes ___ No ___

Special utensils/equipment: _____

Uses a straw: Yes _____ No _____

Food allergies: _____

Medications taken with: Water Applesauce Chocolate Pudding Vanilla Pudding
 Other _____

4. Mobility & Physical Support

Two-person lift required: Yes No

Walks independently: Yes No

Walks with assistance: Yes No

Uses Cane, Crutches, Walker: Yes No

Wheelchair type: Manual Electric

Uses braces: Yes No

Other mobility needs: _____

5. Toileting Needs

Uses toilet independently: Yes No

Uses urinal: Yes No

Wears diapers: Yes No Size:

Uses suppositories/fleets: Yes No If yes, How often?

Other toileting needs:

6. Hygiene & Personal Care

Bathing preference: Shower Bath |Prefers daily every other day

Needs help brushing teeth: Yes No

Needs help with hair or shaving: Yes No

Uses aftershave/perfume/makeup: Yes No

Uses lotions/creams: Yes No

Menstruation care- Independent Yes No

Other hygiene notes:

7. Sleeping Needs

Sleeps on back: Yes No

Wears pajamas: Yes No

Takes nap during day: Yes No

Bedrails needed: Yes No

Uses CPAP Machine: Yes No

Nighttime braces/equipment: _____

Other sleep notes:

8. Swimming Needs

Uses life jacket: Yes No

Uses inner tube: Yes No

Wears swim diapers: Yes No

Other swimming needs:

9. Communication & Social Interaction

Can talk verbally: Yes No Speaks Clearly: Yes No

Uses communication device/word board: Yes No

Communicates via eye blinks: Yes No

Uses Sign Language: Yes No

Uses Gestures: Yes No

Speaks but may be difficult to understand: Yes No

Enjoys socializing: Yes No

Needs prompting for social contact: Yes No

Other communication notes:

10. Vision/Hearing

Vision – Normal: Yes No

Wears Corrective Lenses: Yes No

Hearing – Normal: Yes No

Wears Hearing Aids: Yes No

Notes:

11. Sensory Profile

Check all that apply:

Tactile: (touch sensitivities, avoids textures, seeks touch, etc.)

Vestibular: (movement sensitivity, avoids equipment, etc.)

Proprioceptive: (grinds teeth, needs deep pressure, etc.)

Auditory: (sound sensitivities, fearful of noise)

Oral: (picky eater, difficulty chewing)

Olfactory: (smell sensitivities)

Visual: (light sensitivity, distracted visually, poor spatial awareness)

NOTES:

12. Activities & Interests

Check all that apply:

Swimming Arts & Crafts Talent Show

Sensory Room Games Park Time Computer Room Friends

Other favorite activities:
