



SHADY OAKS CAMP

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Adult Camper Application and Confidential Health History Form 2026

General Information

Please Print All Information Please Email or Mail to above, after completing.

Returning Camper New Camper

Camper Name:

Birthdate

Male Female

Home Address:

Phone:

Email address:

Emergency Contact

Name:

Relationship:

Address

Home Phone:

Cell:

Email address:

Healthcare Provider

Primary Care Physician:

Phone:

Healthcare Insurance

Insurance Company:

Insurance Company Phone:

Certificate/Policy/ID#:

Group# (if applicable):

Name of Policy Holder:

Phone:

Please include a copy (both sides) of your insurance card

Allergies

No Known Allergies

Please list **all** allergies to prescription and non-prescription medications, food, bites, stings, shellfish, iodine, plants & animals

Please describe the reaction and how it is managed:

Do you carry an Epi-pen? Yes No

Dietary/Nutrition

Regular diet Lactose Intolerant Puree Mechanical soft G-Tube
 Both G-tube and oral Requires thickener

Other Dietary things to know about your camper

Please take the time to thoroughly complete this information so that Shady Oaks Camp may provide the best service and appropriate care to meet the needs of the Camper identified above. All sections must be completed and you must sign the Physician Authorization that appears on the final page of this Camper Health Form.

Physician's Name:	
Office Address:	
Phone Contact:	
Last Exam	
Diagnosis – Camper is under my care for treatment of the following diagnosis / condition(s):	

General Health History

Yes	No	Please check yes or no for each question. If yes, elaborate in the space provided or attach an additional sheet with further details.	
		Hospitalizations/Emergency Room visits in the past year?	
		Surgery/Serious injuries in past 5 years?	
		Recurrent/Chronic illness?	
		Cardiac conditions or chest pain during exercise?	
		High Blood Pressure	Treated with medication?
		Bleeding Disorder?	
		Neck, back, knee, shoulder, ankle problems?	
		Skin conditions?	
		Asthma or other respiratory conditions?	
		Experience headaches?	
		Problems with diarrhea/constipation?	
		Experience fainting or dizziness?	
		Experience sleepwalking?	
		If female, problems with menstruation?	
		Diabetes	
		Seizure disorder?	Date of last seizure:
		Depression/Anxiety?	
		Eating Disorder?	
		Wear glasses, contacts, or protective eyewear?	
		Learning Disabilities?	
		Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (ADHD)?	
		Received medical care for a disease or condition in the past 3 months?	
		Exposed to contagious disease in the last 4 weeks?	

If camper has history of Seizures:

Type: _____

Frequency: _____

Duration: _____

Trigger(s): _____

Date of Last Seizure: _____

Are the seizures currently under control? _____

Please provide camp staff with Seizure action plan with medications to treat and how to best care for camper during and after a seizure and when you are to be notified

Medications

Medication is any substance a person takes to maintain and/or improve their health.
This includes vitamins & natural remedies.

- All prescribed medications must be prepacked in individual envelopes for each time and day and their original bottle or blister pack from the pharmacy with the original prescription from the prescribing physician. All over the counter medications must be brought to Camp in their original bottles. Prescription medications with altered labels will not be accepted. The dosage and schedule on the pharmacy label must match the information on the Health Form signed by the physician. Shady Oaks Camp Staff will not accept pre-poured medication or anything in individual envelopes that does not match with the physician's order.
- If camper requires crushed medication, medication must be brought to camp crushed, Med staff will not crush medications.
- Inhalers **must** be in their **prescription labeled box**.
- Bring sufficient amount of each medication to last the duration of camp.

The following non-prescription medications and related treatments are stocked in the Camp Health Office. They are used on an as needed basis to manage non-emergency illness and injury. Please check those that the Camper may take while attending camp if necessary: **Please indicate if camper requires liquid form of OTC medications**

- | | |
|--|--|
| <input type="checkbox"/> Tylenol (Acetaminophen) | <input type="checkbox"/> Miralax |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Milk of Magnesia |
| <input type="checkbox"/> Sudafed | <input type="checkbox"/> Tums |
| <input type="checkbox"/> Sudafed PE | <input type="checkbox"/> Pepto Bismol |
| <input type="checkbox"/> Robitussin | <input type="checkbox"/> Imodium |
| <input type="checkbox"/> Robitussin DM | <input type="checkbox"/> Mylanta |
| <input type="checkbox"/> Mucinex | <input type="checkbox"/> Pepcid AC |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Antibiotic ointment |
| <input type="checkbox"/> Claritin | <input type="checkbox"/> Calamine lotion |
| <input type="checkbox"/> Zyrtec | <input type="checkbox"/> Hydrocortisone 1% |

Please provide camper current vaccination form

What have we forgotten to ask? Please use this space to add any additional information that would be helpful to the camp staff for you to have a successful camping experience.

Authorization for Health Care:

Please note, Camp currently uses Silver Cross Hospital in New Lenox, Illinois and its affiliated clinics and providers for emergency medical treatment. Non-emergency medical treatment will be provided to your Camper by Camp's Medical Staff. Camp will not transport Campers to any non-emergency medical or other appointment(s) scheduled during a Camp Session. If your Camper develops an illness at Camp, you must make immediate arrangements to have your Camper picked up from Camp and be treated by your Camper's primary care physician. Campers will only be allowed to return to Camp to complete his/her Camp Session upon Camp's receipt of a written Release signed by the Camper's primary care physician

The information provided in this Camper Health History Form is true and accurately reflects the current health status of the Camper identified above. As the Camper's Parent / Legal Guardian (select one), I hereby give my permission for Camper to participate in all Shady Oaks Camp activities with the exception of those specifically identified herein:

I further authorize the Executive Director and/or the Medical Staff at Shady Oaks Camp to order X-Rays, routine tests and treatment related to the health of the Camper identified above for both routine health care and in emergency situations. If neither I, nor the emergency contacts listed hereof, or the physician identified hereof, can be reached in an emergency, I give my permission to the Executive Director and/or the Medical Staff at Shady Oaks Camp to hospitalize, secure and administer treatment for, and if applicable, order injection, anaesthesia or surgery for the Camper identified above. I give my permission to the staff at Shady Oaks Camp to provide or arrange for any transportation required for the Camper identified above to receive necessary medical treatment. I give my permission to all persons and entities to release all records required for insurance and/or treatment purposes, and specifically authorize any treating physicians or other medical staff to discuss the health status of the Camper identified above during the period between _____ (Camp Session) as necessary to provide care and treatment to the Camper.

Parent / Legal Guardian Signature: _____
Date: _____

Camper Primary Care Physician:

Name: _____
Office Address: _____
Phone: _____

To Be signed by Physician

I have personally examined the Camper identified above and/or am personally familiar with the health history of the Camper. I have discussed the Shady Oaks Camp program with the Camper and the Camper's Parent or Legal Guardian and it is my professional opinion that the Camper identified above is physically and emotionally fit to participate in the 2026 Shady Oaks Camp Summer Session.

I have completed the Shady Oaks Camp Health History Form and confirm that the information provided therein is true and accurate as of the date below my signature.

Physician Signature: _____
Date: _____

Shady Oaks Camp – Camper Waiver & Release

As a condition of participation in the Summer Camp Program at Shady Oaks Camp, this Camp Waiver and Release Form must be completed and signed by the Camper's Parent or Legal Guardian and returned prior to participation.

Please initial each statement below to indicate your understanding and acceptance of the terms:

Initial: _____ On behalf of my Camper, I acknowledge that activities—including swimming, nature walks, and field trips—may involve hazards. I consent unless I provide written notice otherwise.

Initial: _____ I assume all risks and agree that Shady Oaks Camp, its staff, volunteers, and representatives are not responsible for injury or damages.

Initial: _____ I grant permission for my Camper to attend all field trips and use third-party transportation.

Initial: _____ I grant permission for Medical Staff to provide medical attention, including hospital care. I understand I am responsible for all medical expenses and will provide an insurance card.

Initial: _____ I understand emergency care may occur at Silver Cross Hospital and I am responsible for confirming insurance coverage and meeting staff there if needed.

Initial: _____ I acknowledge the Executive Director may deny admittance if my Camper arrives ill or injured. I authorize Camp to document conditions with photographs.

Initial: _____ I agree to disclose any accident, illness, or surgery before attending Camp and hold Shady Oaks harmless for related complications.

Initial: _____ I consent to the use of my Camper's photographs/videos for advertising, social media, and promotional use without compensation.

Initial: _____ I understand Camp is not responsible for lost or damaged belongings. Valuables and electronics are not allowed unless pre-approved in writing.

Initial: _____ I understand missed or early-ended sessions are non-refundable.

Initial: _____ I confirm my Camper is not aggressive or violent. If my Camper endangers self or others, they may be expelled immediately. No refund will be given.

By signing below, I acknowledge that I have read and understand all Camp policies.

Parent/Guardian Signature: _____

Date: _____

Shady Oaks Camp – Voluntary Demographic & Socio-Economic Information

Completion of this form is voluntary and will NOT affect your camper's opportunity for attendance.

This information is used only for grant reporting. Please do NOT provide any personally identifying information.

Camper's Gender

- Male
- Female
- Other
- Decline to Answer

Camper's Race / Ethnicity

- Asian (Not Hispanic or Latino)
- Black or African American (Not Hispanic or Latino)
- Hispanic or Latino
- Native American or Alaska Native (Not Hispanic or Latino)
- Native Hawaiian or Pacific Islander (Not Hispanic or Latino)
- White (Not Hispanic or Latino)
- Two or more races (Not Hispanic or Latino)
- I do not wish to disclose

Camper's Veteran Status

- Camper identifies as a veteran classification
- Camper does NOT identify as a veteran

Veteran Classifications (Definitions)

- Disabled Veteran: Entitled to VA compensation or discharged for service-connected disability.
- Recently Separated Veteran: Discharged within the last 3 years.
- Active Duty Wartime/Campaign Badge Veteran: Served during a war or authorized campaign.
- Armed Forces Service Medal Veteran: Served in a qualifying operation.

Camper’s Family Combined Household Income

- Below \$50,000 per year
- \$50,001 – \$100,000 per year
- \$100,001 – \$150,000 per year
- \$150,001 – \$200,000 per year
- \$200,001 – \$250,000 per year
- Above \$250,000 per year

T-SHIRT ORDER FORM

Each Camper will receive one (1) Camp T-Shirt included in the cost of the Camper’s Camp Fee. Additional T-Shirts may be purchased in advance for the prices identified below. Please complete this T-Shirt Order Form and submit it along with your 2025 Camp Application Packet with payment for the total order. NO CHILD SIZES ARE AVAILABLE.

CAMPER NAME: _____

TOTAL T-SHIRTS ORDERED – INCLUDING CAMPER’S FREE SHIRT: _____

Camper T-Shirt Size _____ (NO CHARGE)

SIZE PRICE QUANTITY AMOUNT DUE (PRICE X QUANTITY)

SMALL \$15.00 _____ \$ _____

MED \$15.00 _____ \$ _____

LARGE \$15.00 _____ \$ _____

X LARGE \$15.00 _____ \$ _____

XX LARGE \$20.00 _____ \$ _____

XXX LARGE \$20.00 _____ \$ _____

TOTAL AMOUNT DUE: \$ _____

SEIZURE ACTION PLAN (SAP)



Name _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.** Notify emergency contact at _____
- Give rescue therapy according to SAP Call 911 for transport to _____
- Notify emergency contact Other _____

First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure** Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens _____
- Other _____

When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

[Type here]



When rescue therapy may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____ Name of Med/Rx _____ How much to give (dose) _____ How to give _____

If seizure (cluster, # or length) _____ Name of Med/Rx _____ How much to give (dose) _____ How to give _____

If seizure (cluster, # or length) _____ Name of Med/Rx _____ How much to give (dose) _____ How to give _____



Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History

_____ Allergies _____

Epilepsy Surgery (type, date, side effects) _____ Device:

VNS RNS DBS Date Implanted _____ Diet Therapy

Ketogenic Low Glycemic Modified Atkins Other (describe) _____ Special Instructions:



Medication prepackage options that are acceptable

SHADY OAKS CAMP

SUGGESTED CLOTHING AND EQUIPMENT LIST

Camper Name: _____

Session/Date: _____

Each item of clothing **must be marked** with the name of the camper to assist with identifying the camper's belongings when repacking. Name tape or a permanent ink marker should be used to mark the camper's belongings. All non-clothing items (i.e. flashlights, crutches, pillows, etc.) should be also marked.

Campers who wear Depends® or diapers must have water proof covers or pool diapers/Depends® in order to swim.

All Campers must supply their own wheelchairs, diapers, swim diapers, catheters, colostomy bags, medication, special eating utensils, and all other medical equipment/supplies.

Please do not send valuable personal property to Camp (ie. iPods, digital cameras, sports equipment, games, jewelry, etc.) as Camp will not be responsible for any loss or damage to same. Additionally, Wi-Fi service may not be available at Camp to please download any apps, movies or other items your Camper may need.

Please do not send food or drink, unless required for a special diet.

Item	#Sent	#Returned	Item	#Sent	#Returned
Pajamas			Jacket/Rain Gear		
Socks			Sweatshirt / Sweater		
Underwear			Robe / Slippers	/	
Bras					
Long Pants / Jeans	/		Pillow(s)		
Shorts			Blanket(s)		
Shirts / T-Shirts	/		Towels (Including Pool)		
Dress			Other:		
Bathing Suit			DIAPERS – minimum change of 4 per day		
Swim Trunks			Sanitary Napkins		
Sneakers			Q-Tips		
Shoes / Boots	/		Bug Repellent		
Sandals			Sun Screen / Lotion		
Pool Shoes			Glasses/Sunglasses		
Shower Shoes			Hats		
Toiletry Bag			Laundry Bag		
Bar (Gel) Soap			Suitcase		
Shaving Items			Swim Diapers		
Toothbrush in covered container (Must have 2)			Water Proof Covers		
Item	# sent	# Returned	OTHER ITEMS:		
Tooth Paste					
Shampoo			Please List all other Medical Equipment Below		
Deodorant					
Comb/Brush					
Powder					