

Misquah Cottage Experience
Application Form-Summer 2010
13 Sherry Lane
Ottawa, Ontario
K2G 3L4

(Charitable Organization #129815118RR1)

Note: In order to reserve a place for the applicant in the desired session, a non-refundable one hundred dollar **(\$100.00) deposit** must accompany this application. The **balance** is to be paid by **June 1st, 2010**. Due to increased costs, fees have been raised to \$595.00 per session.

In cases of financial hardship, **subsidy assistance is available**. The amount of the balance may be reduced or the payment deadline extended with approval from the Director. Refunds will only be made, less the deposit provided the space can be filled. Exceptions may be made for medical reasons, only with a written request accompanied by the applicant's physician.

Checks must be made payable to: **Community Cottage Experience**

SESSION	DATES	ARRIVAL	DEPARTURE	COST
#1	July 3 rd – 9 th	3:00pm	1:00pm	\$595.00
#2	July 10 th – 16 th	3:00pm	1:00pm	\$595.00
#3	July 17 th – 23 rd	3:00pm	1:00pm	\$595.00
#4	July 24 th – 30 th	3:00pm	1:00pm	\$595.00
#5	July 31 st –Aug. 6 th	3:00pm	1:00pm	\$595.00
#6	August 7 th – 13 th	3:00pm	1:00pm	\$595.00

Please indicate t-shirt size: ___ (sm) ___ (med) ___ (lg) ___ (xl) ___ (xxl)

Please Print All Information:

Applicant Name: _____ Age: _____

Address: _____

Official Receipt to: Name _____
 Address _____

Individuals able to answer specific questions regarding needs, behaviors, etc: Please check box to indicate whether ___ Parent ___ Foster Parent ___ Caregiver ___ Worker

Name _____ Phone _____ (Day) _____ (Eve)

Please list two emergency contacts who will be available during the cottage session:

(1) Name _____ Phone _____ (Day) _____ (Eve) _____

(2) Name _____ Phone _____ (Day) _____ (Eve) _____

How does the applicant communicate? English French Sign Bliss:

Other: _____

Has the applicant had previous cottage vacation experience? Yes No. If yes please give details.

Guests must provide their own transportation to and from the cottage. Please provide transportation details.

Driver's Name _____ Arrival Time _____ Pick-up Time _____

Applicant Health Information

Name: _____ Date of Birth: _____ Sex: M F

Height: _____ Weight: _____ Health Card Number: _____

Group or Other Plan Number: _____ Name of Subscriber: _____

Name of Physician: _____ Phone Number: _____

Address: _____

Health History **(Confidential)**

If applicant has had any of the following, please check.

Immunization (give date of most recent)

(1) Tetanus, Diphtheria, Polio: _____ (2) Hepatitis B: _____ (3) Measles, Mumps: _____

(4) Rubella: _____ (5) Tuberculosis: _____

Communicable Diseases (please check)

Chicken Pox Mumps Tuberculosis Red Measles Hepatitis
 Mononucleosis German Measles Whooping Cough Other (Specify) _____

Other Health Issues (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Homesickness |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Severe Stomach Ache | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Sight Difficulties | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Hepatitis A or B |
| <input type="checkbox"/> Other (specify) _____ | | |

State recent operations, illness or injuries: _____

Treatment for above noted Health Issue: _____

List any specific camp activities to be encouraged or limited: _____

Describe any treatments to be given at cottage: _____

List any concerns regarding food preparation (puree, small bites): _____

Bathing requirements (full assistance, partial assistance, bath/shower): _____

Toileting requirements (reminding, assistance, cleanliness): _____

Medications

PLEASE LIST ALL MEDICATIONS TAKEN BY THE APPLICANT AND HOW THEY ARE TO BE ADMINISTERED. PLEASE NOTE TIMES THAT THE MEDICATIONS ARE TAKEN AT HOME SO THAT APPLICANT'S SCHEDULE WILL NOT BE AFFECTED. **NOTE:** FOR PRESCRIBED CREAMS AND TOPICAL OINTMENTS, PLEASE INDICATE AREAS TO BE COVERED.

Name of Medication	Dosage	When Administered	Reason for Taking
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This Application CANNOT be processed without the following signatures:

To the best of my knowledge, the applicant is in good health. Should he or she be in contact with an infectious disease before departure for the cottage program, I understand the Director must be notified. In case of surgical emergency and we are not immediately available for consultation, I hereby give permission to the physician selected by the Director, to hospitalize, secure proper treatment and to order injections, anesthesia or surgery for the applicant. I also give permission for the Cottage Director, or other qualified staff member, to administer non-prescription medications within recommended dosages if required.

Authorized Signature: _____ Date: _____

Must Be Signed

Relationship to applicant _____

I agree to waive any claims made upon the Misquah Group, the Cottage Owner or their agents in the event of any injury that may be sustained in connection with the program.

Signature: _____ Date: _____

Must Be Signed

I Hereby give permission for photographs/movies to be taken during the cottage session and for the publication or use of photograph(s), slides or video-taped material of the above-named applicant in brochures and/or other promotional material of the Misquah Group.

Signature _____ Date _____

Misquah Recreational Group Health Certificate

Important – This form must be completed by a physician and returned with every client application form.

Client's Name: _____

Previous Medical History	Current Medications
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

1. Has the client been hospitalized within the last year? Explain

2. Does the client have any allergies? Please list.

3. Has the client had a seizure within the last year? If so, please give date/type.

Upon examination of the medical records of the client noted above, I attest that the above information to be accurate and current. I believe the client to be physically and medically capable of attending an outdoor recreational summer camp.

Physician's Signature

Date