



# The Zajac Ranch for Children Camp Application Form

**Application Deadline: 6 weeks prior to your requested camp session**

Dear Parents/Guardians:

Thank you for applying to the Zajac Ranch for Children. Please read the following information carefully. If you have any questions about the application process you may contact the Registration Coordinator at 604-739-0444.

To apply to camp you must send in a complete application form – see the checklist below to make sure your application is ready to mail. Applications will not be processed until all necessary information is received, along with camp fee payment (see page 9), which will be held until your application is approved. If you are unable to pay camp fees, please complete the Subsidy Request section on page 9.

We do our best to not turn any campers away due to medical or financial need, but we do have a limited number of spaces per camp session, so get your application form in early!

All applications will be reviewed by the Zajac Ranch Nursing Director, who will contact you if there are any questions/concerns. Acceptance letters and packages will be sent by mail to the address you provide.

## Your application must include:

- Photo of the camper (for counsellors to quickly identify your child and their needs) **\*Very important**
- General Information – name and contact information
- Signed Consent for Medical Treatment/Signed Photo Release permission (Please print and complete)
- General Medical History
- List of Medications
- Completed Physical Care Requirements
- Medical Form **completed, stamped and signed** by a physician
- Payment Detail Form (cheque attached or credit card) or Subsidy Request completed

*\* Please note: Incomplete information will hinder the processing of your application*

Please send completed applications to:

**The Zajac Ranch for Children  
Attn: Registration Coordinator  
#300 – 2006 West 10<sup>th</sup> Ave.  
Vancouver, BC V6J 2B3  
info@zajac.com**



# Zajac Ranch for Children Camper Application Form

Deadline: 6 weeks prior to your requested camp session



PLEASE PRINT CLEARLY

OR COMPLETE ELECTRONICALLY AND PRINT OUT WHEN FORM IS COMPLETED

Please select from drop-down menu the preferred session date(s) for your camper:

CAMP SESSION	
1 <sup>st</sup> Choice	
2 <sup>nd</sup> Choice	
3 <sup>rd</sup> Choice	

**APPLICATION: MR. LUBE**  
 Were you referred? Yes  No   
 If yes, by whom? (Please name)  
 Mr. Lube Franchisee:  
 Hospital/Med. Org:  
 Other:

CAMPER APPLICANT INFORMATION					
First Name		Last Name		Gender	
Preferred Name/ Nickname		Birthdate (DD/MM/YYYY)		Grade in School	
Address		City		Province	
Postal Code		Phone	( ) -		
Email		Primary Language			
Diagnosis					
Care Card/ Health Number		Doctor's Name		Doctor's Phone	( ) -
Hospital		Specialist's Name		Specialist's Phone	( ) -

PARENTS/GUARDIANS INFORMATION					
	Name	Relationship	Work Phone	Cell Phone	Email
1			( ) -	( ) -	
2			( ) -	( ) -	
3			( ) -	( ) -	

If child does not live with all guardians listed above, which has legal custody?

EMERGENCY CONTACT (To be contacted if parents/guardians cannot be reached)			
Name	Relationship to Camper	Daytime Phone	Evening Phone
		( ) -	( ) -

PICK-UP AUTHORIZATION (If someone other than a parent/guardian will pick up camper on closing day)			
Name	Relationship to Camper	Daytime Phone	Evening Phone
		( ) -	( ) -

Applicant Name: \_\_\_\_\_

Session: \_\_\_\_\_

**TO BE SIGNED BY PARENT/GUARDIAN**

**WAIVER AND CONSENT FOR MEDICAL TREATMENT**

I, \_\_\_\_\_, hereby grant permission to the nurses, staff and consulting physicians at the Zajac Ranch for Children to administer medication and provide medical and other care for \_\_\_\_\_, including transportation deemed necessary or appropriate in connection with the treatment of my child. I also assume full financial responsibility for any and all medical and other expenses incurred for or on behalf of my child while at the Zajac Ranch for Children or offsite. I authorize the Camp Director or his appointee to authorize on my behalf all procedures, including admission to hospital and necessary treatment therein, as he may deem essential for the care and well being of my child. Such action is only to be taken when immediate contact with parents/guardians cannot be made.

I permit my child to participate in the full range of camp activities and absolve the Zajac Ranch for Children and the Mel Jr. & Marty Zajac Foundation and all related organizations from responsibility for any injuries resulting from these activities. I assume full responsibility for any damage or destruction of camp property as a result of the actions of my child, and I understand that I will be billed for any such damage and/or destruction

I understand all information pertaining to my child will be treated confidentially by the Zajac Ranch for Children. However, I agree that said information may be shared with/released to appropriate personnel and/or third parties for the purpose of treating and/or supervising my child (including, but not limited to nursing, medical and other camp staff, The Zajac Foundation, and the Zajac Ranch for Children insurance companies).

**AUTHORIZATION FOR THE USE OF PHOTOS AND NAME**

I, \_\_\_\_\_, authorize The Zajac Foundation and the Zajac Ranch for Children to use any photos of \_\_\_\_\_ taken during their camp session. The Zajac Foundation and Zajac Ranch for Children may also use the first name, age, and camp session my child attended in photo captions, newsletters, etc.

**I FULLY UNDERSTAND AND AGREE TO THE TERMS STATED ABOVE.**

\_\_\_\_\_  
Parent/ Guardian Signature

Date (DD/MM/YYYY): \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Session: \_\_\_\_\_

### GENERAL MEDICAL HISTORY

To be completed by parent/guardian

**Drug Allergies:** Please list all allergies or indicate "none" if none exist

**Dietary Allergies/Restrictions:** Please list all allergies/restrictions or indicate "none"

**Medical History:** (include any other illnesses, medical problems, or special needs of your child we should be aware of)

**My child is subject to, or has had:**

- |  |   |
|--|---|
| <input type="checkbox"/> ADD/ADHD                                    | <input type="checkbox"/> Hay fever                            |
| <input type="checkbox"/> Appendicitis                                | <input type="checkbox"/> Heart condition                      |
| <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Hepatitis                            |
| <input type="checkbox"/> Atlanto-Axial X-ray Please indicate results | <input type="checkbox"/> Hypertension                         |
| <input type="checkbox"/> Bronchitis                                  | <input type="checkbox"/> Kidney Disease                       |
| <input type="checkbox"/> Chicken pox                                 | <input type="checkbox"/> Measles                              |
| <input type="checkbox"/> Ear infections                              | <input type="checkbox"/> Migraines                            |
| <input type="checkbox"/> Eczema                                      | <input type="checkbox"/> Mumps                                |
| <input type="checkbox"/> Epilepsy                                    | <input type="checkbox"/> Rheumatic fever                      |
| <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> Seizures: Date of last seizure _____ |
| <input type="checkbox"/> Frequent colds                              | Seizure Type: _____ Frequency _____                           |
| <input type="checkbox"/> German Measles                              | <input type="checkbox"/> Tuberculosis                         |
| <input type="checkbox"/> HIV   |   |
| <input type="checkbox"/> Other (please specify): _____               |   |

Has your child been recently hospitalized?  Yes  No

If yes, indicate dates and reason \_\_\_\_\_

Are your child's immunizations up to date:  Yes  No

If no, what is missing? \_\_\_\_\_

Year of last Tetanus (dpt, dt): \_\_\_\_\_

**Applicant Name:** \_\_\_\_\_  
**Session:** \_\_\_\_\_

**MEDICATION**

**Note: All medications administered at camp (including over-the-counter medicines and vitamins) must be written on this form.**

Each family should send all medications and any other supplies necessary for their child while at camp. The medical staff will store and administer medications as directed by you. **Please send all medications in their original bottles, properly labelled with your child's name. They must have correct pharmacy labels.**

Drug Name & Strength	Dose	Frequency
<b>Supplemental Nutrition:</b>		

\* Please indicate any special ways to give medications. Include information about medications used to prevent nausea and vomiting and pain management if applicable. We know that medication schedules may change before the summer; please inform us if changes occur.

Applicant Name: \_\_\_\_\_

Session: \_\_\_\_\_

## PHYSICAL CARE REQUIREMENTS

Physical Restrictions or Limitations (Select all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Wheelchair    | <input type="checkbox"/> Amputation       |
| <input type="checkbox"/> Crutches/Cane | <input type="checkbox"/> Artificial Limb  |
| <input type="checkbox"/> Walker        | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Splint/Brace  | <input type="checkbox"/> Vision impaired  |

Is your camper able to walk 4 city blocks without requiring a rest? \_\_\_\_\_

Additional Information/Comments:

Please describe your child's eating habits:  Fussy  Average  Hearty

Does he/she require 1:1 care throughout the day?  Yes  No

Level of Assistance for your child (Please check appropriate column for each category)

	Independent	Close Supervision	Moderate Assistance	Total Care
Daily Care (brushing teeth, combing hair, dressing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing/Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting/Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does camper have problems with bed-wetting?  Yes  No

If the camper is female has she begun her menstrual period?  Yes  No

**\* If YES to either of the above please provide enough supplies (plus a few extra) for the length of the whole camp**

Additional

Information/Comments:

Applicant Name: \_\_\_\_\_

Session: \_\_\_\_\_

## BEHAVIOURAL CONCERNS

Please select all that apply:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Punching/Hitting    | <input type="checkbox"/> Running           | <input type="checkbox"/> Attention Seeking  | <input type="checkbox"/> Risk to Others |
| <input type="checkbox"/> Risk to Self        | <input type="checkbox"/> Easily Frustrated | <input type="checkbox"/> Sensitive to Noise | <input type="checkbox"/> Homesickness   |
| <input type="checkbox"/> Other, Please list: |  |   |   |

Please explain possible cause of behaviour and how you deal with them:

**How often does your child require close supervision? Please provide accurate examples!**

- All of the time       Some of the time       None of the time

Additional Information and/ or Comments:

## SOCIAL AND EMOTIONAL ADJUSTMENT QUESTIONNAIRE

**How does your child interact in a group of children the same age?**

**Interests/Hobbies**

**Dislikes**

Please provide any other important information that would be beneficial for the Staff of the Zajac Ranch to provide the ultimate camp experience:

Applicant Name: \_\_\_\_\_  
Session: \_\_\_\_\_

**MEDICAL FORM**

**(CAMPERS MUST HAVE THIS FORM COMPLETED AND SIGNED BY A PRACTISING LICENSED PHYSICIAN)**

**NOTE:** The person being evaluated will be attending one week of camp. The experience may include sleeping on the ground and participating in activities such as hiking, canoeing, and large group games. Please review the health history with the participant for any interim changes.

Campers name \_\_\_\_\_ DOB \_\_\_\_\_ Date of Exam \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Please list any Current Problem(s):

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Please list any surgeries below:

Date \_\_\_\_\_ Procedure \_\_\_\_\_

Date \_\_\_\_\_ Procedure \_\_\_\_\_

Date \_\_\_\_\_ Procedure \_\_\_\_\_

Date \_\_\_\_\_ Procedure \_\_\_\_\_

**PHYSICAL EXAM:** Please list any pertinent findings OR attach a recent H&P.

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Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

Vision: \_\_\_\_\_  Normal  Glasses  Contacts

Hearing: \_\_\_\_\_  Normal  Abnormal  Explain \_\_\_\_\_

**Medications:** (Note: We realize that medications and schedules may change before the summer; a “late changes” form will be included in the camper’s final approval packet which will be brought to camp with the camper. All campers are responsible for bringing their own medications and supplies).

Name:	Dose:	Route:	Frequency:

**\*\*\*Please ensure that ALL medication is in the original packaging. Failure to do so will result in your child being sent home to get proper medication containers. Our nursing staff are not legally permitted to monitor and/or distribute medication not in original containers.\*\*\***

**Applicant Name: \_\_\_\_\_**

**Session: \_\_\_\_\_**

**Medical Form Continued**

**Please List any dietary needs or restrictions for this camper:**

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**Regarding this child's social development; would s/he communicate and interact with peers and others in an age appropriate manner?  Yes  No**

**If no, what additional supports are needed to make this a successful camping experience?**

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**Are there any behavioural concerns that would affect the child's participation in a group?**

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**I \_\_\_\_\_ have examined \_\_\_\_\_ and find her/him able to attend camp.**

**\_\_\_\_\_  
Signature of Physician**

**\_\_\_\_\_  
Print Name**

**\_\_\_\_\_  
Date**

Applicant Name: \_\_\_\_\_

Session: \_\_\_\_\_

## PAYMENT OF CAMP FEES

Is your child attending with a medical organization?  Yes  No

If yes, please specify Medical Group from drop-down menu:

If the organization is not listed, please specify:

If you have indicated **YES** to the above, all payments should be made through the organization you have specified. Please contact your organization should you have any questions regarding camp fees.

If you have specified **NO**, please fill out payment details below as full payment is required upon registration

### METHOD OF PAYMENT

CHEQUE ATTACHED (Please make cheque payable to The Zajac Ranch for Children)

Credit Card Type:  VISA  MasterCard  Other

Name on Card	Card Number	Expiry	MM/YY
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NOTE: All payments will be withheld until acceptance is confirmed. Once accepted, we will process camp payment and issue your receipt along with acceptance package to the Camper Address specified above.

If you are unable to pay the deposit, or any other part of the camp fees, please complete subsidy request form below.

## SUBSIDY REQUEST FORM

1. AMOUNT FAMILY CAN CONTRIBUTE	\$
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2. AMOUNT OF SUBSIDY REQUESTED	\$
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3. Total Cost of Session (Sum of 1 & 2)	\$
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Number in Household

List total number of persons living in your house who are included in your living expenses:

### Household Income

Include wages of ALL working members of the household.

Please mark the box which most closely represents your annual gross income.

\$0-24,999     \$25,000-\$49,999     \$50,000-\$74,999     \$75,000-\$99,000     \$100,000 +

Campership awards are based on availability of funding. The Zajac Ranch for Children strives to provide assistance to all in need, however this is not always possible. Please write in 300 words or less why you believe the Zajac Ranch would be a beneficial experience for your child. **(This paragraph is mandatory)**

Please write your paragraph here.

Please read and complete: I/We give permission for the Zajac Ranch for Children to use our name and our child's name to raise funds for campership assistance, specifically for our family. Notification of camperships will be sent by mail. I/we understand that any campership awarded will be reduced in the event of a credit balance from outside groups and/or parental/guardian payments. *In the event of such over payment, campership funds awarded by the Zajac Ranch for Children will be used to assist another camper.*

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

All information included will be held strictly confidential.