Dear Parents,

Camp Wonder Hands is a unique summer camp for deaf and hard-of-hearing children. This camp originated over 20 years ago as an idea of Marolyn W. Amick, a Child Life Specialist at Prisma Health Children’s Hospital–Midlands. Mrs. Amick, who herself is hard-of-hearing and has a child who is deaf, felt the need to provide an atmosphere where deaf children would be able to identify with others and learn that they are not alone in their experience.

This year Camp Wonder Hands will be held **Sunday, June 21 through Friday, June 26, 2020**, at Camp Kinard in the Batesburg-Leesville community. There will be swimming, games, crafts, community presenters, and lots of fun. We invite teen campers ages (16) sixteen to (17) seventeen years of age to attend this summer camp without cost. The Camp Wonder Hands teen program vision is to provide a positive and nurturing environment that will stimulate personal growth, increase self-esteem and give each teen camper the tools needed to make constructive, informed decisions that will shape a future of success.

Please complete all forms of the enclosed application and return the packet to the return address provided or by email as an Adobe PDF attachment to register your child/children for an experience of a lifetime. **REGISTRATIONS MUST BE POSTMARKED ON OR BEFORE MONDAY, MARCH 16, 2020 TO BE ELIGIBLE TO ATTEND CAMP. REGISTRATIONS CAN NOT BE ACCEPTED AFTER THIS DATE.**

Please register early, because space is limited and we want your child to have a summer to remember. Should you have any questions, feel free to contact Camp Wonder Hands Director E.T. Taylor at CampWonderHands@PrismaHealth.org. For additional information, call Children’s Hospital at (803) 296-KIDS (5437) and we’ll get back to you as soon as possible.

Thank you for your time. We look forward to enjoying the company of your children this summer. Please feel free to make copies of this packet and pass it on to family members, friends and any others who you think may be interested in sending a child to Camp Wonder Hands.

Sincerely,

E.T. Taylor, RN, BSN, Director,  
Camp Wonder Hands  
Prisma Health Children’s Hospital–Midlands

Marolyn Amick, Founder–Emeritus  
Camp Wonder Hands  
Prisma Health Children’s Hospital–Midlands

**Disclaimer:** Please be advised as you complete this year’s Camp Wonder Hands application, do not alter the format of this form. Either print the application and complete it handwritten or type the requested information. Any application submitted in an alternative format will not be accepted. Thank you.
Teen Camper Application Form

Camper’s Full Name: ________________________________________________________________

Nickname: ________________________________________________________________

Date of Birth: ___________________ Age: ___________________

Race: ___________________ Sex: ___________________

Home Address: ________________________________________________________________

_________________________________________________________

County: ________________________________________________________________

Parent/Guardian: ________________________________________________________________

Home Phone: ________________________________________________________________

Cell Phone: ________________________________________________________________

Work Phone: ________________________________________________________________

Employer: ________________________________________________________________

Home Email Address: __________________________________________________________

Work Email Address: __________________________________________________________

With whom does the child live?: __________________________________________________

Relationship to camper: ________________________________________________________

Home Phone: ________________________________________________________________

Cell Phone: ________________________________________________________________

Work Phone: ________________________________________________________________

School Attends: _____________________________________________________________

Grade Attending in Fall: ______________________________________________________
EMERGENCY CONTACT

(Primary Contact)
Emergency Contact Name:______________________________________

Relationship to Camper:________________________________________

Home Phone:___________________________________________________

Cell Phone:____________________________________________________

Work Phone:___________________________________________________

(Secondary Contact)
Emergency Contact Name:______________________________________

Relationship to Camper:________________________________________

Home Phone:___________________________________________________

Cell Phone:____________________________________________________

Work Phone:___________________________________________________
Camper Health Information Form
For Camping Session June 21-26, 2020

Please note: The following information that you are required to submit will be kept in the strictest confidence in keeping with all healthcare privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA). This information will only be shared with the Director of the camp representing Camp Wonder Hands and Children’s Hospital Administration.

HEALTH HISTORY

Is your child in Good Health? ☐ Yes ☐ No

Check any Diagnosis that applies:
☐ Heart Defect/Disease ☐ Asthma
☐ Convulsions/Seizures ☐ Cancer
☐ Diabetes ☐ ADHD/ADD
☐ High Blood Pressure ☐ HIV/AIDS
☐ Kidney Disease ☐ Other Diagnosis

Please explain in detail any diagnosis checked above:

________________________________________________________________________
________________________________________________________________________

List any physical restrictions or limitations.

________________________________________________________________________
________________________________________________________________________

Describe any recent injuries or surgeries.

________________________________________________________________________
________________________________________________________________________

Other medical problems or disabilities.

________________________________________________________________________
________________________________________________________________________
From a developmental perspective, does your child function at his/her calendar age?  □ Yes  □ No

If not, please explain your child’s specific delays, challenges or special needs.

__________________________________________________________________________________

__________________________________________________________________________________

Has your child had chickenpox?  □ Yes  □ No

Mumps?  □ Yes  □ No

Primary Physician:_________________________________________________________________

Address & Phone:_________________________________________________________________

__________________________________________________________________________________

Primary Dentist:_________________________________________________________________

Address & Phone:_________________________________________________________________

__________________________________________________________________________________

MEDICATIONS

Is this child currently taking any medications?  □ Yes  □ No

If yes, list the drugs:

__________________________________________________________________________________

__________________________________________________________________________________

Will this medication be needed during Camp?  □ Yes  □ No

(If medications are needed during camp, please ensure that the Camp Medical Staff is provided with correct medications in the correct amount to cover the time your child will be in our care.)
ALLERGIES

☐ Hay Fever  ☐ Poison Ivy/Oak
☐ Insect Stings  ☐ Drugs (Penicillin, etc.)
☐ Food  ☐ Others (Specify)

Please explain in detail any allergies checked above:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

IMMUNIZATIONS

Are Immunizations up to date?  ☐ Yes  ☐ No

Has this child had a Tetanus shot?  ☐ Yes  ☐ No

If not in the last 10 years, then you must receive a Tetanus Shot and provide documentation to that effect prior to Camp.

Please indicate any further information about your medical needs or medical history that would be helpful.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
COMMUNICATION/SOCIALIZATION

How do you communicate?
☐ Sign Language
☐ Lip Reading
☐ Speech
☐ All of the Above

Is your child Deaf?  □ Yes  □ No
Is your child Hard-of-Hearing?  □ Yes  □ No
Does your child wear a HEARING AID/S?  □ Yes  □ No
Does your child wear a Cochlear Implant?  □ Yes  □ No
Does your child use ASL Sign Language?  □ Yes  □ No
Does your child use another form of Sign Language?  □ Yes  □ No
Does your child have any other disabilities?  □ Yes  □ No

If Yes, please explain the disability your child has.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

In an effort to ensure that we support each and every one of your child’s needs while at Camp Wonder Hands, please share any special accommodations that your child receives at school?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**SWIMMING**

Can this camper swim?  □ Yes  □ No

If yes, how well?

Does this child have any limitation that would prevent him/her from participating in any activities?  □ Yes  □ No

If yes, please explain:

**CAMP WONDER HANDS T-SHIRT**

Check the appropriate size t-shirt for your child:
- □ Children’s Small (6-8)
- □ Children’s Medium (8-10)
- □ Children’s Large (14-16)
- □ Adult Small
- □ Adult Medium
- □ Adult Large
Camp Wonder Hands
Prisma Health Children’s Hospital–Midlands
Insurance Information

Camper’s Full Name: ____________________________________________

Date of Birth: _________________________________________________

Insurance Company: ____________________________________________

Effective Date: _________________________________________________

If coverage is Medicaid, please give Medicaid number: ______________

Hospital Preauthorization Needed?  □ Yes  □ No

Company Insurance Form Needed?  □ Yes  □ No

Telephone number for Pre-Authorizations: _________________________

Emergency admissions need to be called in within how many working days? __________________________________________

Primary Care Physician’s Name and Phone Number: ________________

________________________________________________________________

Name of Insured: _______________________________________________

Date of Birth: _________________________________________________

Policy Number: ________________________________________________

Group Number: ________________________________________________

Telephone Number for Claim Information: _________________________

Mailing address for claims: ______________________________________

________________________________________________________________

(Please send a copy of the front & back of your Insurance Card or Medicaid Card.)
I, ___________________________ hereby consent to and authorize the taking of photographs, motion pictures, and/or television pictures of: ________________________________________________

(camper’s name)

while he/she is attending at Camp Wonder Hands. I also consent to the use of any or all such photographs, motion pictures, and/or television pictures by Camp Wonder Hands’ officials, their representatives, or the publication media.

I hereby give permission to Camp Wonder Hands’ officials and/or the publication media to identify the above camper by name in association with the publication of photographs, motion pictures, and/or television pictures taken while I participate as a Staff Member/Interpreter at Camp Wonder Hands.

☐ Yes ☐ No

__________________________________
Signature

__________________________________
Relationship to Camper

__________________________________
Witness

__________________________________
Date
Consent for Medical Treatment/Hospitalization
Prisma Health Richland Hospital
Camp Wonder Hands
June 21-26, 2020

I, _______________________________ hereby give my consent for Camp Wonder Hands’ officials, its nurses, or other personnel to render and/or obtain medical treatment for:

________________________________________
(camper’s name)

while he/she is attending Camp Wonder Hands.

Additionally, I hereby authorize Camp Wonder Hands’ officials, its nurses or other personnel to admit the above-named Staff Member/Interpreter to Prisma Health Children’s Hospital–Midlands if it is determined that hospitalization is necessary.

I know and understand that I am financially responsible for the medical care and treatment rendered to the above named camper if there is a charge for the medical services provided.

____________________________________
Signature

____________________________________
Relationship to Camper

____________________________________
Witness

____________________________________
Date
Consent for Participation
Camp Wonder Hands
June 21-26, 2020

I, We, ____________________________ do hereby (parents or legal guardian)

consent to our child’s participation at Camp Wonder Hands. We understand that our child may take part in camping activities such as swimming, canoeing, hiking, and other sports. We understand that Camp Wonder Hands is designed to provide a happy and safe camping experience for our child. However, should an unforeseen accident occur, we will not hold Prisma Health Children’s Hospital, its staff, camp counselors, or camp medical staff responsible. We understand we may withdraw our consent and withdraw our child from camp at any time we wish. We understand that Medical Staff volunteering for camp will not require payment for services, but if emergency department services are used or if another physician is used, we will be billed for these services.

__________________________________
Parent(s)/Legal Guardian(s) Signature(s)

__________________________________
Parent(s)/Legal Guardian(s) Signature(s)

__________________________________
Date
Teen Camper Letter of Recommendation

Child’s Name:______________________________________________

How long have you known this child?:____________________________________

____________________________________________________________________

____________________________________________________________________

In what relationship/capacity did you come to know this child?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

What qualities does the child possess that will make him/her a good camper at Camp Wonder Hands?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Signature

____________________________________________________________________

Address

____________________________________________________________________

Home Number

____________________________________________________________________

Date
Camp Wonder Hands 2020

Parents:
Please complete & returned this application
to the mailing or email address below by

Camp Wonder Hands
Attn: E.T. Taylor, Camp Director
Prisma Health Children's Hospital–Midlands
7 Richland Medical Park Drive
First Floor Admin Suite
Columbia, S.C. 29203
CampWonderHands@PrismaHealth.org

Thank you for your interest in
Camp Wonder Hands!