Malta Camp USA
July 9-13, 2023

***Guest* Application and Medical Release Authorization Form**

If filling out a paper (or PDF) application form, please scan and send to info@maltacampusa.org with the subject line "Guest Application - FIRSTNAME_LASTNAME":

Print or type your responses to all questions

A. Personal Information

Send a digital photo of any size photo to info@maltacampusa.org

Last Name _____ First: _____

Nickname: _____ Sex: ❑ Male ❑ Female

Date of Birth: _____ Height: _____ Weight: _____

Home Address:

_____

City: _____ State: _____ Zip: _____

Preferred Phone Number: _____

Email Address: _____

Marital Status: _____ Name of Spouse (if married) _____

Ages of minor children (if any): _____ _____ _____ _____ _____ _____

Shirt Size: _____

B. Malta Camp USA

How did you learn about Malta Camp USA? If from a previous camp volunteer or current member of the Order of Malta, please let us know who shared this opportunity with you.

_____

_____

What leads you to apply to Malta Camp USA?

Did you attend Malta Camp USA 2022? Have you attended an international Malta Camp?

Are you affiliated with the Order of Malta? Do you know someone who is part of the Order? If so, who?

C. Background

Please describe your home setting. Do you live at home, in a community setting, or independently?

Do you have a job? If so, please describe the type of work you do, your hours, whether you are mostly standing or sitting, etc.

Tell us about your typical day at work.

Do you volunteer with any organizations? If so, please describe what type of volunteering you enjoy.

What type of activities do you enjoy? E.g. games, sports, arts and crafts, singing, dancing, music, etc.

What type of activities are you involved in? E.g. clubs, teams, choirs, art classes, music classes, etc. Do you participate in any local community organizations?

Is there anything you do not like and/or are afraid of? E.g. dogs, water, loud noises, etc.
If so, please share it with us.

Is there anything else you enjoy that you did not list above? If so, please share it with us.

D. Personal Health

Please describe your primary disability (in layman's terms):

Please describe any additional conditions:

Are you currently under a physician's care? ❑ Yes ❑ No

How often do you see your physician? ❑ Weekly ❑ Biweekly ❑ Monthly ❑ Semi-Annually

What is that physician's specialty? _____

Do you require assistance with:

Stepping into high tub? ❑ Yes ❑ No

Moving about? ❑ Yes ❑ No

Bathing? ❑ Yes ❑ No

Dressing? ❑ Yes ❑ No

Standing/Sitting? ❑ Yes ❑ No

Eating? ❑ Yes ❑ No

Correctly dosing/timing medication? ❑ Yes ❑ No

Any part of basic care (bathing/dressing/eating)? ❑ Yes ❑ No

If you answered yes to any of the above questions, please explain:

_____

_____

_____

_____

Have you recently:

Experienced disorientation or loss of consciousness? ❑ Yes ❑ No

Experienced dizziness? ❑ Yes ❑ No

Loss of balance? ❑ Yes ❑ No

Fallen? ❑ Yes ❑ No

Do you require a: ❑ Cane ❑ Walker ❑ Wheelchair

Do you have special equipment needed at the camp? ❑ Yes ❑ No

If yes, please describe usage and type of equipment.

_____

_____

_____

_____

List ALL medications, including dosages, schedule, and for what condition.

Medication	Dosage	Schedule

Please list required supplements.

_____

_____

_____

_____

_____

_____

_____

If needed, can you take these over the counter medications:

Acetaminophen (Tylenol) ❑ Yes ❑ No
Ibuprofen (Advil) ❑ Yes ❑ No
Diphenhydramine (Benadryl) ❑ Yes ❑ No

If you answered no, please explain:

_____

_____

_____

Primary Physician's contact information:

Last Name: _____ First Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax Number: _____

Email Address: _____

Please list any additional specialist physicians:

1. Last Name: _____ First Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax Number: _____

Email Address: _____

---

2. Last Name: _____ First Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax Number: _____

Email Address: _____

---

3. Last Name: _____ First Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax Number: _____

Email Address: _____

Immunization information:

Date of your most recent tetanus immunization (mm/yyyy): _____

Please note Malta Camp USA will be adhering to CDC, New York state, and local guidelines to prevent the spread of COVID-19. Additional details to follow.

Emergency Contact Information

Name of Contact: _____ Relationship: _____

Address of Contact: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Email address: _____

Medical Insurance

Primary Health Insurance Company: _____

Policy/Group #: _____ Telephone (toll-free number): _____

I authorize the Order of Malta, American Association to receive and use my protected health information, as defined under applicable law, for the purpose of participating in Malta Camp USA.

This authorization is voluntary.

I authorize the Order of Malta, American Association physicians to consult with my personal physicians and consultants listed.

I authorize the Order of Malta, American Association to include photographs of me during Malta Camp USA and including them in publications, including the Order of Malta website.

I confirm the information provided on all forms reflects my personal and health information accurately and is true to the best of my knowledge.

Authorizing Signature: _____ Date: _____

Print Name: _____

Relationship: Self Parent/Guardian Personal representative