camp FUEL

GET REVVED UP FOR FUN!

presented by easterseals Crossroads

Thank you for your interest in Camp Fuel which will be located at J. Everett Light Center located at 1901 East 86th Street. We are excited that you and your family are considering sending your loved one to spend time with us this summer! For eligibility requirements, please see camp flyer.

Camp Fuel is all about experiences and skill building for adolescents between the ages of 11 to 17 years old. As a participant, your child will benefit from **F**un and **U**nique **E**xperiential **L**earning activities at Camp FUEL this summer. From skill building and special guests, to building friendships and going on field trips, we'll be sure your child is all revved up and engaging in the fun!

Below you will find a list of the registration forms (mandatory and supplemental) that must be completed in order for your child to attend Camp Fuel. These forms must be thoroughly completed and submitted with all supporting documents and the camp deposit in order to secure a spot. Your child's spot will not be confirmed until we have all necessary documents and information, they have been reviewed for eligibility, and deposit has been secured. ***Registration forms are due April 28, 2017.***

☐ **MANDATORY FORMS:**

☐ **SUPPLEMENTAL FORMS:**

For questions regarding camp or to submit payment and registration forms, please contact:

Easterseals Crossroads, Attn: Karen Kelley
4740 Kingsway Drive
Indianapolis, IN 46205
Phone: 317.466.1000 | Fax: 317.466.2000 | Email: kkelley@eastersealscrossroads.org

2017 Annual Camp Registration Forms

Directions: Page 2 should be completed once for your family and pages 3-5 for each participant.

Parent/Guardian/Caregiver Information:

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____

Email address: _____

Other than those listed above, the following people are authorized to pick up/drop off the participant *(ID required)*

Name: _____ Phone: _____

Name: _____Phone: _____

Name: _____ Phone: _____

Individuals Attending Respite Programs:

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

EMERGENCY CONTACT INFORMATION (other than parent/caregiver listed above):

1. Name: _____ Relation to participant: _____

Home Number: _____ Cell Phone Number: _____

2. Name: _____ Relation to participant: _____

Home Number: _____ Cell Phone Number: _____

Preferred Hospital: _____ Preferred Doctor: _____

Address: _____ Phone: _____

By signing below, I acknowledge the following: *I have provided Easterseals Crossroads with the most recent and up-to-date information including health, medical and authorized pick up user information for the above listed participant(s). In addition, I have attached all of the required support plans in order to ensure participants have a safe and healthy experience while participating in the Respite events. I understand if the individual's behavior poses a threat to his safety or the safety of others, the individual may need to be withdrawn from the program. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified above for the participant.*

Parent/Guardian Signature: _____ **Date:** _____

Participant Information

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Primary Disability: _____ Secondary Disability: _____

Allergies (meds/food): _____

School Classroom Setting (i.e. general education, special education, ABA center etc.): _____

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.) ☐ yes ☐ no

If yes, please explain_____

Ethnicity:

☐ African American ☐ Native American ☐ Asian American ☐ Caucasian
☐ Hispanic ☐ Multiple Ethnicities ☐ Other: _____

Support plans:

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

☐ Individualized Education Plan ☐ Behavior Support Plan ☐ Individual Support Plan

☐ Seizure Management Plan ☐ Other: _____ ☐ Not Applicable; Reason: _____

Levels of Care:

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

Toileting

☐ Participant is fully independent

If not, please circle which of the following are applicable:

Reminders	Diapers
Assistance with clothing	Assistance with washing hands
Assistance after a bowel movement	Assistance transferring on/off toilet

Please describe: _____

Ambulation/Risk of Falling (Seizures)

☐ Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

Use of wheelchair	Risk of falling due to instability
Use of prosthetics/orthotics	Risk of falling due to seizures
Requires assistance ambulating/transferring	Other: _____

Please describe: _____

Medication Administration

☐ Participant will frequently require medication administration while at Respite events
(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)

☐ Participant will not require medication administration while at Respite events

☐ Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

Please describe: _____

_____

Level of Supervision Needed

☐ Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision

☐ Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants

☐ Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants

☐ One-on-One – participant requires an adult by their side at all times in order to remain engaged

How does you child respond to new environments?: _____

Leisure Activities

Please circle activities that your child enjoys participating in:

Outside/Playground	Video games/electronics	Gym
Arts/Crafts	Movies	Painting/Coloring
Sports	Pretend Play	Board Games
Reading Books	Music/Dancing	Other: _____

Please describe: _____

Nutrition/Feeding

☐ Participant is fully independent

If not, please circle which of the following are applicable:

Special preparation of food (i.e. pureed, soft, cut into small pieces, etc)

Food allergies	Diabetic
G-tube feedings	Diet restrictions
Bottle feeding	Choking risk
Assistance opening packages	Assistance with feeding/using utensils
Picky eater (please list preferred foods below)	Snack will be provided by parent/caregiver

Please describe: _____

_____

Communication

☐ Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

Requests items by pointing	PECS (**p**icture **e**xchange **c**ommunication **s**ystem)
Sign/Gestures/ASL	Writing/Visual schedules/Word cards
Communication device	One or two word phrases
Vocalizations/sounds	Unable communicate needs

Please describe*:* _____
_____

Sensory

Please indicate by circling which of the following may impact the participant's behavior/participation:

Bright lights/Sunlight	Hot/Cold	Touch	Sounds/Loud noises
Animals	Thunderstorms	Other: _____	

The participant enjoys the following sensory activities:

Ear protection	Chewy toys	Weighted blankets/vests
Light-up objects	Water play	Deep pressure hugs/massage
Body brushing	Fuzzy toys	Other: _____

Please describe: _____
_____

Behaviors

Directions: Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
Example: Does not comply with requests	*3 times*	*per*	hour	
Scratches, pinches, bites, or hits self		*per*		
Scratches, pinches, bites, or spits on others		*Per*		
Bangs head		*Per*		
Grabs others		*Per*		
Pulls Hair		*Per*		
Runs away/risk of elopement		*Per*		
Gets into/takes others personal belongings		*Per*		
Strips down clothing/exposes self in public		*Per*		

Reservation and Payment Information

Participant Name: _____ Date:_____

Cost: Camp FUEL costs $300 per session ($199 early bird special if registration is received between January 16th and February 28th; $100 deposit plus $99).

To reserve a spot at Camp FUEL you must include the following:

- A **$100** deposit **per camp session** (the deposit is refundable if cancellation occurs two weeks or more prior to the session start date).
- All completed registration forms with doctors signatures (where needed)
- Support plans / Supplemental Forms

Please indicate below which sessions the participant will attend:

☐ **Session 1:** June 12 – June 22 (Mondays – Thursday)

☐ **Session 2:** June 26 – 30 (Monday-Friday)
July 5 – 7 (Wednesday-Friday)

***PLEASE NOTE-FIRST WEEK WILL RUN MONDAY THROUGH FRIDAY**
SECOND WEEK WILL RUN WEDNESDAY THROUGH FRIDAY

☐ **Session 3:** July 10 – 20 (Monday - Thursday)

Payment Information (please check one):

☐ **CHECK** (*made payable to Easterseals Crossroads):*

I have enclosed a check in the amount of $ _____ to cover the $100 deposit that is due for **each session** that we have indicated we'd like to attend.

☐ **CREDIT/DEBIT:**
I authorize Easterseals Crossroads to charge my credit/debit card in the amount of $_____ to cover the $100 deposit that is due for **each session** that we have indicated the above listed participant will attend.

Credit Card: ☐ Master Card ☐ Visa ☐ Discover Card ☐ American Express

Credit Card Number: _____ Expiration Date: _____

_____ _____
Cardholder's Printed Name Cardholder's Signature

Once we receive the completed registration forms and payment, we will send you a confirmation letter letting you know that your spot for camp has been reserved.

Authorization to Use Likeness/Information

Consumer Name: _____ Date of Birth _____

I, or my legal representative, understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Crossroads or its respective employees and agents may be used by Easterseals Crossroads and those acting with its permission for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Crossroads and that these materials may be released to the general public. I assign to Easterseals Crossroads all of my rights to these materials.

I understand that these materials made by Easterseals Crossroads, its employees and agents are owned by Easterseals Crossroads and that they may copyright them. I further consent to allow Easterseals Crossroads, their respective employees and agents, and those acting with Easterseals Crossroads' permission to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Crossroads and to release this information to the general public.

I understand that these materials may be published by Easterseals Crossroads on the Internet. This may disclose my image, name and diagnosis, which is considered personal and protected health information. Easterseals Crossroads does not need to submit these materials to me for further approval and I further understand that Easterseals Crossroads may decide not to use these materials.

I acknowledge that the rights described above are granted to Easterseals Crossroads on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Crossroads will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Crossroads to release my protected health information, including image, name and diagnosis if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Crossroads in writing by sending my revocation to Easterseals Crossroads, Marketing Department, 4740 Kingsway Drive, Indianapolis, IN 46205.

I understand and agree that once Easterseals Crossroads, its respective employees and agents, and those acting with its permission disclose my protected health information, including image, name and diagnosis, as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires five years from the date of my signature below.
I have read this release and authorization before signing below, and I fully understand its contents.

_____ _____

Signature of Consumer or Legal Representative **Date**

_____ _____

Printed Name of Consumer or Legal Representative **Relationship to Consumer**

_____ _____

Witness **Date**

Acknowledgement of Receipt of Participant Handbook

I, _____, the parent/guardian of _____
(Parent/Guardian Name) **(Primary Participant's Name)**

sign below acknowledging the receipt of the Parent/Guardian & Participant Handbook and agree to comply with the policies and procedures set in place. I understand that it is my responsibility to read through and familiarize myself with the handbook and to ask questions about anything I do not understand.

_____ _____
Signature **Date**

Camp FUEL | Transportation Consent Form

Participant Name: _____ Date: _____

I/we grant permission to Camp FUEL at Easterseals Crossroads to escort the above named participant off the premises for community integration experiences / field trips which will be supervised by the camp staff and provided via staff vehicles. I hereby resolve the Board of Directors and staff of all liability, except in the event of injury arising from negligence on the part of the agency, its personnel, subcontractors, or volunteers.

I give permission to Easterseals Crossroads to obtain emergency treatment form any of the physicians or hospitals I have indicated on the registration form in the event I or my dependent suffer(s) illness or accident.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician's Medication Administration Form

Participant's Name _____

Date of Birth _____ Child's Weight _____

PRESCRIPTION MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)

Camp staff have permission to give the above listed participant, _____,
the following medication(s) _____

Day(s)/Time(s) to be given _____

Dosage/Route _____

Reason for medication _____

Should the medicine be taken with food or milk? _____Yes _____ No

Any other special instructions? _____

_____

OVER-THE-COUNTER MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)

Do you want camp and enrichment staff to administer over-the-counter medications when necessary and then according to recommended dosage for the child's weight/age? _____ Yes _____ No

If yes, what medications will you provide for your child to take and for what purpose?

_____

_____

_____ _____

Printed Name of Physician **Physician's Signature**

_____ _____

Physician's Phone Number **Physician's Address**

_____ _____

Parent/Legal Guardian Signature **Date**

Scholarship Application Form

A limited number of scholarships are available for the camp and enrichment programs at Easterseals Crossroads. Please complete this form to apply for a scholarship, and return it with your registration form. Please note that we can only scholarship one session of camp or enrichment programs and that the family is still responsible for the $100 deposit even if awarded the scholarship.

It is necessary to include a copy of your most recent tax return and the following if applicable:

- A copy of your last two month's pay stubs
- If unemployed, a copy of your last two month's unemployment check stubs
- Copy of paperwork documenting retirement, disability or social security benefits
- Copy of document citing child support or alimony awarded by a judge

This information will only be used to determine scholarship eligibility.

CONSUMER INFORMATION	
Child's name:	Parent's Name:

HOUSEHOLD INFORMATION

Number of family members in household:

____ Mother ____ Father

____ Children ____ Other Adults

Gross Annual Income (including parent's earned income, child support, disability income, and worker's compensation):

$ _____

SIGNATURE

Signature of individual providing information:

Patient/Guardian signature *Date*

For Office Use Only:

____ Scholarship approved and family notified

____ Scholarship denied and family notified

Before and After Care

Participant Name: _____ **Date:** _____

Easterseals Crossroads is pleased to offer before and after camp care to children who participate in Camp FUEL. Families interested in receiving care, must complete the form below and attach the appropriate payment. The cost for after care is in addition to the regular camp fee. Please note the fee structure below. We encourage families to pre-arrange after care, as we cannot guarantee the availability of staff on an as-needed basis.

Pre-arranged (on or before June 5th): $7 per hour, per child

As-needed basis (after June 5th): $10 per hour, per child

Directions: Please check (x) the boxes that express the dates/times you are interested in receiving before and after care for the above listed participant.

Session 1: June 12 – June 22				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 12				
Tuesday, June 13				
Wednesday, June 14				
Thursday, June 15				
Monday, June 19				
Tuesday, June 20				
Wednesday, June 21				
Thursday, June 22				
			TOTAL DUE:	$

Session 2: June 26-July 8				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 26				
Tuesday, June 27				
Wednesday, June 28				
Thursday, June 29				
Friday, June 30				
Wednesday, July 5				
Thursday, July 6				
Friday, July 7				
			TOTAL DUE:	$

Session 3: JULY 10-20				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, July 10				
Tuesday, July 11				
Wednesday, July 12				
Thursday, July 13				
Monday, July 17				
Tuesday, July 18				
Wednesday, July 19				
Thursday, July 20				
			TOTAL DUE:	$

GRAND TOTAL DUE: $

(add totals from session 1,2 and 3)

I agree to pay the fees listed above. I understand that if plans change and I no longer need before or after care for my child on a date that I have indicated, I will be reimbursed those fees at the conclusion of camp.

Parent/Caregiver Signature: _____ Date: _____

Special Preparation and Food Allergy Plan
Supplemental Form

Participant Name: _____ Date: _____

A. Special Food Preparation

Indicate texture of food needed:

☐ Regular ☐ Chopped ☐ Mechanical Soft ☐ Pureed

Indicate thickness of liquids needed (thickening agent must be provided by family):

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

B. Food Allergies

What food(s) is the participant allergic to?

☐ Milk/Dairy
☐ Eggs
☐ Peanuts
☐ Soy
☐ Gluten
☐ Wheat
☐ Dyes or coloring
Please specify: _____
☐ Other: _____

What type of contact induces an allergic reaction?

☐ Ingesting the allergen
☐ Eating near others with the allergen
☐ Ingesting food with the allergen
☐ Any exposure
☐ Other: _____

What signs will we see if the participant is having experiencing an allergic reaction?

☐ Skin rash/hives
☐ Difficulty breathing
☐ Upset stomach/bowels
☐ Anaphylaxis
☐ Swelling of lips
☐ Swelling in tongue
☐ Dizziness
☐ Drop in blood pressure
☐ Closed throat
☐ Other: _____

If experiencing an allergic reaction, will we see signs/symptom immediately or is there a delayed response? _____

Please number the procedures below in order of desired emergency care:

_____ Call parent/guardian immediately participant is showing signs/symptoms of an allergic reaction.

_____ Call 911 if signs/symptoms of an allergic reaction appear.

- Under what circumstances should staff contact 911? _____
  _____

_____ Administer emergency medication (Epi-pen, inhaler, Benadryl).

- Under what circumstances should staff administer emergency medication?___
  _____
- Can the participant self-administer the emergency medication? ☐ yes ☐ no

Directions: Please complete the table below with a list of safe snacks and unsafe snacks for the participant. We cannot guarantee that safe snacks will be provided during respite events, so if your loved one has an allergy please be prepared to send them with a snack to the event so that they can enjoy in snack time with their peers.

Safe Snacks	Unsafe Snacks

C. General Information

Can the participant identify foods that are safe to eat? ☐ yes ☐ no

Can the participant inform an adult if they are having an allergic reaction? ☐ yes ☐ no

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

_____ _____

Parent Signature **Date**

For staff use only:

This form was received and reviewed by:

_____ _____

Name / Title **Date**

Seizure Action Plan
Supplemental Form

Participant Name: _____ Date: _____

Basic Information: Please provide background information on the nature of the seizures (i.e. type, triggers, length, etc.)

Seizure Type	Length	Frequency	Description

1. Are there triggers/warning signs? _____

_____

2. How will the participant respond/behave once the seizure is over? _____

_____

History & Management of Seizures:

1. When was the participant's last seizure? _____
2. Has the participant been hospitalized for continuous seizures? ☐ yes ☐ no
3. Does the participant have a Vagus Nerve Stimulator (VNS?) ☐ yes ☐ no

   B. Describe use of the magnet: _____

   _____

4. Does the participant take medication(s) for their seizures? ☐ yes ☐ no

   A. Will this medication need to be administered at the Respite event? ☐ yes ☐ no

Medication	Dose	Route of administration (i.e: oral, rectal, etc.)	The medication is for emergencies only
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

** If medication (including emergency meds) is needed during the Respite event, parents/caregivers must complete a medication administration form which will be provided at sign-in to each event. Medication must be in original container.*

Seizure Emergency Protocol: please list out directions for staff to follow in the instance that the participant has a seizure during a Respite event.

If the participant has a	Call 911	Administer Diastat or utilize VNS

typical seizure please do the following…	immediately if…	magnet if….
1. 2. 3. 4. 5.		

Basic Seizure First Aid:

- Stay calm and track the time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with the child until they are fully conscious
- Protect the head
- If tonic clonic, place child on side and keep airway open for breathing

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

_____ _____

Parent Signature **Date**

For staff use only:

This form was received and reviewed by:

_____ _____

Name / Title **Date**