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, Indianapolis. 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 20, 2018.***

☐ **MANDATORY FORMS:**

☐ **SUPPLEMENTAL FORMS:**

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

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

2018 Camp FUEL Application

ALL FORMS MUST BE <u>COMPLETELY</u> FILLED OUT. ***PLEASE PRINT CLEARLY.***

CAMPER INFORMATION

First Name: _____ Last Name: _____ Goes By: _____
Birth date_____ /_____ /_____ Age _____ Sex _____ Weight _____ Height _____

Primary Diagnosis:_____

Secondary Diagnosis:_____

Your camper's T-shirt size: **ADULT** - ☐ SMALL ☐ MEDIUM ☐ LARGE ☐ XL ☐ XXL ☐ XXXL
YOUTH - ☐ SMALL ☐ MEDIUM ☐ LARGE

PARENT/ GUARDIAN INFORMATION

Parent/Guardian 1:

First Name: _____ Last Name: _____ Email:

_____

Street Address

_____

City _____State _____ Zip Code

_____County_____

Main Phone Number (_____) _____ Type: ☐ Mobile ☐ Home ☐ Work

Other Phone Number (_____) _____Type: ☐ Mobile ☐ Home ☐ Work

Parent/Guardian 2:

First Name: _____ Last Name: _____

Email:_____

Street Address _____

City _____State _____ Zip Code _____County_____

Main Phone Number (_____) _____ Type: ☐ Mobile ☐ Home ☐ Work

Other Phone Number (_____) _____Type: ☐ Mobile ☐ Home ☐ Work

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: _____

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: _____

Transportation Authorization: I acknowledge and give permission for my child to be transported via bus or staff vehicles for field trips during Camp FUEL.

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:** _____

CAMPER HISTORY

To be completed by camper's parent/guardian. ***PLEASE PRINT CLEARLY!***

Diet: ☐ Normal ☐ Blended/Pureed ☐ Gluten Free ☐ Vegetarian ☐ Dairy Free
☐ Other **IF OTHER THAN NORMAL DIET PLEASE COMPLETE A SPECIAL FOOD PREP SUPPLEMENTAL FORM**

Mobility: ☐ Walks ☐Uses Walker ☐Uses Wheelchair; can operate/drive self? ☐ Yes ☐ No
☐ Orthotic Braces/Ankle-Foot orthosis (AFO)

Seizures: ☐YES ☐NO **IF YES PLEASE FILL OUT A SEIZURE SUPPLEMENTAL FORM**

Allergies: (Check all that apply)
☐ None ☐ Pollen ☐ Poison Ivy ☐ Latex ☐ Animals ☐ Bee/Insects ☐Food
☐ Medications ☐ Peanuts ☐ Other _____ **IF CAMPER HAS FOOD ALLERGIES PLEASE FILL OUT A FOOD ALLERGY SUPPLEMENTAL FORM**

Special Equipment: (check all that apply)
☐ Orthopedic Devices ☐ Glasses ☐ Contacts ☐ Dentures ☐ Earplugs ☐ Helmet ☐ Catheter
☐ Ostomy ☐ Feeding Tube ☐ Hearing Aid ☐ Orthodontic Braces ☐ Dental Appliances
☐ Other: _____**IF CAMPER HAS FEEDING TUBE PLEASE FILL OUT G-TUBE FEEDING SUPPLEMENTAL FORM**

Communication: (check all that apply)
☐Camper can effectively communicate needs ☐Signs, gestures, vocalizations

☐PECS ☐Writing/Visual Schedules/Cards

☐Communication Device ☐Unable to communicate needs
PleaseDescribe:_____
_____

Camp Activities:
Are there any activities your camper should **not** participate in? ☐ YES ☐ NO
If yes, list:
_____

Swimming:
Can Camper Swim independently? ☐ YES ☐ NO
If NO, please explain assistance needed (water wings, personal flotation device, counselor assistance)
_____

Hospitalizations:
Please list recent surgeries *(within the last 12 months)*:
_____

Please list recent hospitalizations *(within the last 12 months)*:

_____
_____
_____
_____

Sensory: Please indicate by circling which of the following may impact the camper's behavior:

Bright lights/Sunlight Smells Touch Sounds/Loud noises

Animals Thunderstorms Other: _____

The camper 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:

_____

_____

_____

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*		

Please describe any other identified behaviors and frequency:

_____

_____

_____

_____

_____

_____

_____

_____

Behavior Modification/Management:
Are there any specific behaviors or skills you have been working on, or would recommend working on as a proposed behavior modification/management goal (i.e. independent washing of hands, use of silverware, appropriate eye contact, decrease inappropriate behaviors, etc.)?

_____
_____
_____
_____
_____

Academic Skills: ☐ Reading skills: To what degree? _____
☐ Writing skills: To what degree? _____
☐ Math skills: To what degree? _____

Does your camper attend school: ☐ YES ☐ NO Grade Enrolled *(if applicable)* _____
Is your camper in a special education class? Yes ___ No ___ Other _____
Does camper have IEP and/or behavior plan? Yes___ No___ **COPY OF CURRENT IEP MUST BE PROVIDED**
Does your camper have an aide? Yes____ No____
If yes, in what capacity does the aide assist camper?_____
_____
_____

Does your child have a nurse? Yes____ No_____
If yes, in what capacity does the nurse assist camper?
_____
_____
_____
_____
_____
_____

Therapy:
Does camper receive therapy services? ☐ YES ☐ NO

If yes, what type of therapy does camper receive?
_____
_____
_____
Are there any specific skills camper has been working on, or any recommendations from therapist that would benefit camper while at camp? If so, please describe below.
_____
_____
_____
_____
_____

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: _____

Authorization to use Likeness/Information/Photo Release

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

Reservation and Payment Information

Participant Name: _____ Date:_____

Cost: Camp FUEL costs $300 per session ($199 early bird special if registration is received between January 22nd and February 23rd; $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 11 – June 21 (Mondays – Thursday)

☐ **Session 2:** June 25 – 29 (Monday-Friday)
July 2 & 3 (Monday and Tuesday)
***PLEASE NOTE-FIRST WEEK WILL RUN MONDAY THROUGH FRIDAY**
SECOND WEEK WILL RUN MONDAY AND TUESDAY

☐ **Session 3:** July 9 –19 (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.

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**

Before and After Care

Camper Name: _____ Date: _____

Easterseals Crossroads is pleased to offer before and after 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 before and after care is in addition to the regular camp fee. Please note the fee structure below. We encourage families to pre-arrange before and after care, as we cannot guarantee the availability of staff for care on an as-needed basis.

Pre-arranged (on or before June 4th): $7 per hour, per child
As-needed basis (after June 4th): $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 camper.

Session 1: June 11 - June 21				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 11				
Tuesday, June 12				
Wednesday, June 13				
Thursday, June 14				
Monday, June 18				
Tuesday, June 19				
Wednesday, June 20				
Thursday, June 21				
			TOTAL DUE:	$

Session 2: June 25 – July 3				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 25				
Tuesday, June 26				
Wednesday, June 27				
Thursday, June 28				
Friday, June 29				
Monday, July 2				
Tuesday, July 3				
			TOTAL DUE:	$

Session 3: July 9 – July 19				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, July 9				
Tuesday, July 10				
Wednesday, July 11				
Thursday, July 12				
Monday, July 16				
Tuesday, July 17				
Wednesday, July 18				
Thursday, July 19				
			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: _____

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

Special Preparation and Food Allergy Plan

Supplemental Form

Camper 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 camper 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 camper 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 typical seizure please do the following…	Call 911 immediately if…	Administer Diastat or utilize VNS 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**