



Thank you for your interest in CampAbility which is located at Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240. We are excited that you and your family are considering sending your loved one to spend time with us this summer!

CampAbility is a traditional, non-academic, day camp designed to serve families of children who present with a primary disability such as cerebral palsy, spina bifida, down syndrome, autism, developmental delays, etc. Should you have questions regarding eligibility for this camp, please contact us.

Below you will find a list of the registration forms (mandatory and supplemental) that must be completed in order for your child to attend CampAbility. These forms must be thoroughly completed and submitted with all supporting documents and the camp deposit in order to secure a spot for camp. Your spot will not be confirmed until we have all necessary documents and information. **Registration deadline is April 20, 2018.**

We have a lot of fun activities planned including field trips, therapeutic horseback riding, special guest visitors and much, much more! We can't wait to hear from you! ☺

MANDATORY FORMS:

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

Easterseals Crossroads **Attn: Angie Hilligoss**
 4740 Kingsway Drive, Indianapolis, IN 46205
 Phone: 317.466.1000 | Fax: 317.466.2000
 Email: ahilligoss@eastersealscrossroads.org

2018 CampAbility Registration

*ALL FORMS MUST BE COMPLETELY FILLED OUT. **PLEASE PRINT CLEARLY.**

CAMPER INFORMATION

First Name: _____ Last Name: _____

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: _____

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 (with staff) for field trips during CampAbility

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 camper(s). In addition, I have attached all of the required support plans in order to ensure campers have a safe and healthy experience while participating in CampAbility. 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 camp. 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 camper.

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

Please Describe: _____

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

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.

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

Camper Name: _____ Date: _____

Cost: CampAbility costs \$300 per session (\$199 early bird special if registration is received between January 22 and February 23, 2018).

To reserve a spot at CampAbility 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
- Current Support plans

Please indicate below which camp you would like the camper to attend and which sessions:

CampAbility - Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240 (Ages 4-10)

Session 1: June 11 – June 21 (Monday – Thursday)

Session 2: June 25 – July 3 ***PLEASE NOTE: THE 1ST WEEK OF SESSION 2 WILL RUN M-F AND THE 2ND WEEK WILL RUN MONDAY & TUESDAY DUE TO THE 4TH OF JULY HOLIDAY**

Session 3: July 9 – July 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 camper 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.

Agape Therapeutic Horseback Riding

Camper Name: _____

Camp Session: _____

Photo and Media Consent

Agape Therapeutic Riding Resources, Inc. requests that the above-listed Agape Equine Participant consent to and authorize the use and reproduction by Agape Therapeutic Riding Resources, Inc. of any and all photographs and any other audio-visual materials taken of the above-listed Agape Equine Participant for publication in promotion material, educational activities, exhibitions, publications, broadcasts, website and any other use which promotes Agape Therapeutic Riding Resources, Inc. and its programs.

Please check *only* one: ____ I do consent. ____ I do **not** consent.

Health History Signature

I hereby affirm that, to the best of my knowledge, the health history information provided within this application is complete and correct.

Name of person completing this form: _____

Relationship to Participant: _____

Signature: _____ Date: _____

EQUINE ACTIVITY RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO INDEMNIFY

This *Equine Activity Release, Assumption of Risk and Agreement to Indemnify* (the "Agreement") is hereby entered by on the dates indicated below.

A. Scope of Services Provided. Agape Therapeutic Riding Resources, Inc. ("Agape") is a not-for-profit organization that sponsors, organizes and/or provides facilities for activities involving equines including, but not limited to, therapeutic riding and equine-facilitated learning programs with such activities taking place both on the premises owned by Agape ("Premises") and at other locations within the State of Indiana ("Locations") (collectively "Agape Equine Activities").

B. Inherent Risks of Equine Activities. The undersigned expressly understands that certain dangers or conditions are an integral part of such Agape Equine Activities including but not limited to: i) The propensity of an equine to behave in ways that may result in injury, harm, or death to persons on or around the equine, ii) The unpredictability of an equine's reaction to such things as sound, sudden movement, unfamiliar objects, people, or other animals, iii) Hazards such as surface and subsurface conditions, iv) Collisions with other equines or objects and v) The potential of a person involved in Agape Equine Activities to act in a negligent manner that may contribute to injury to that person and/or other persons, such as by failing to maintain control over an equine. **The undersigned expressly understands and agrees that such dangers or conditions exist whether a person is: i) personally engaging in Agape Equine Activities, ii) a spectator of Agape Equine Activities or iii) entering, departing or being on the Premises or Locations where Agape Equine Activities are taking place and that by doing any of these actions, such a person is a "Participant."**

C. Assumption of Risk, Release and Waiver of Liability and Indemnity Agreement. In consideration of Agape allowing the undersigned, as well as those persons for whom the undersigned has listed herein, to be a Participant and with an understanding of the Inherent Risks of Equine Activities as set forth in Paragraph B above, the undersigned, individually and on behalf of each persons listed herein by the undersigned, hereby assumes all such risks and forever releases, waives, discharges and covenants not to sue Agape Therapeutic Riding Resources, Inc. (including its directors, officers, shareholders, employees, agents, representatives, volunteers, insurers, affiliates, successors, assigns and others acting on Agape Therapeutic Riding Resources, Inc.'s behalf including, without limitation, independent contractors such as trainers, instructors, veterinary personnel, farriers, equine care providers and maintenance personnel) (collectively the "Released Parties") from all liability, loss, claims, demands, possible causes of action, court costs, attorneys' fees and other expenses, known or unknown, anticipated or unanticipated, that may result from any loss, damage or injury (including death) to the person or property of i) the undersigned and ii) each person listed herein by the undersigned which, in any way, results from, or arises in connection with, or relates to, any Agape Equine Activity whether caused by the negligence of the Released Parties or others. The undersigned further hereby agree to indemnify and hold harmless the Released Parties and each of them from any and all loss, liability, damage or cost they may incur due to the undersigned and each person listed herein by the undersigned being a Participant whether caused by the negligence of the Released Parties or otherwise.

The undersigned agrees that the Indemnification Agreement shall also apply as to any loss, liability; damage or cost incurred by persons and their property who have not executed an *Equine Activity Release, Assumption of All Risk and Agreement to Indemnify* but who the undersigned invited or otherwise encouraged to be a Participant.

D. Binding Effect. This Agreement shall be binding upon the heirs, executors, administrators, agents, insurers and assigns of the undersigned and shall inure to the benefit of and may be enforced by the Released Parties. **If this Agreement is executed for and on behalf of a Participant who is under the age of eighteen (18) or under some other legal disability, the undersigned hereby represents and warrants that he or she is in fact the legal parent or guardian of said Participant with full rights of custody and control and that this Agreement and all terms contained herein is given on behalf of and is intended to be binding upon said Participant, his/her heirs, executors, administrators, agents, insurers and assigns.**

E. Complete Agreement, Choice of Law, Venue and Attorneys Fees. The terms of this Agreement contain the entire agreement of the parties as to the subject matter set forth herein and shall be governed by the laws of the State of Indiana. In the event any provision of this Agreement is deemed to be invalid or unenforceable by any court or

administrative agency of competent jurisdiction, then the Agreement shall be deemed to be restricted in scope or otherwise modified to the extent necessary to render its provisions valid and enforceable. The parties agree that Hamilton County, Indiana is the exclusive venue for any legal proceedings arising from or related to this Agreement and the Released Parties shall be entitled to recover the costs incurred (including reasonable attorney's fees) from the undersigned in the event that any legal action (regardless of whether a lawsuit is filed) is required to enforce this Agreement.

I HAVE FULLY READ AND FULLY UNDERSTAND THIS EQUINE ACTIVITY RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF ALL RISK AND AGREEMENT TO INDEMNIFY. I UNDERSTAND THAT, BY SIGNING THIS DOCUMENT, I MAY BE WAIVING AND RELEASING CERTAIN IMPORTANT RIGHTS WHICH I MIGHT HAVE IF I DID NOT SIGN THIS AGREEMENT. I AM SIGNING THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY COERCION.

ADULT/GUARDIAN(S) FULL NAME

Signature and Date

Name

EACH PARTICIPANT UNDER THE AGE OF 18 OR OTHERWISE UNDER A LEGAL DISABILITY FOR WHOM EACH ADULT PARTICIPANT IS SIGNING (Please Print):

Signature and Date

Name

WARNING

Under Indiana law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

PHYSICIAN'S RELEASE FORM FOR AGAPE

This form is required if: Participant has Down Syndrome AND/OR If one or more of the health questions on pg. 5 of the Health History Form are 'Yes'. Please return this form by mail/fax/email to: Agape Headquarters, 24970 Mt. Pleasant Rd., PO Box 207, Cicero, IN 46034; Fax (317) 984-9103; Email: riders@agaperiding.org.

PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____

Name of Parent(s)/Guardian(s): _____ Phone: _____

PHYSICIAN'S REPORT

Medical	Normal	If not normal, please explain
Appearance and affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Upper Extremities		
Lower Extremities		

FOR PERSONS WITH DOWN SYNDROME

Neurologic exam reveals symptoms consistent with atlantoaxial instability? Yes No Date of Exam: _____
**No individual may ride at Agape with positive symptoms of AAI.*

Jarring Tolerant

For activities at Agape such as horseback riding, can the participant tolerate jarring (circle one)? Yes No
 If no, please explain:

All riding and equine-assisted activities are closely supervised by trained therapeutic riding instructors. Upon reviewing this information and all possible contraindications, please indicate your medical opinion by checking one of the boxes below:

- Full Participation:** Individual may participate in all equine-assisted activities, including riding.
- Partial Participation:** Individual **cannot** participate in the following:
 ___ Horseback riding; ___ Grooming; ___ Other: _____
- No Participation:** Individual **cannot** participate in any equine-assisted activities.

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Agape will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Agape for ongoing evaluation to determine eligibility for participation.

Physician's Signature:

Date:

Physician's Name (please print):

Phone:

Address/City/Zip:

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 CampAbility. 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:				\$
<i>(add totals from session 1, 2 and 3)</i>				

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

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?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Milk/Dairy | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Dyes or coloring
Please specify: _____ | <input type="checkbox"/> Other: _____ |

What type of contact induces an allergic reaction?

- | | |
|---|---|
| <input type="checkbox"/> Ingesting the allergen | <input type="checkbox"/> Eating near others with the allergen |
| <input type="checkbox"/> Ingesting food with the allergen | <input type="checkbox"/> Any exposure |
| <input type="checkbox"/> Other: _____ | |

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

- | | |
|---|---|
| <input type="checkbox"/> Skin rash/hives | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Upset stomach/bowels | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Swelling of lips | <input type="checkbox"/> Swelling in tongue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drop in blood pressure |
| <input type="checkbox"/> Closed throat | <input type="checkbox"/> 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 camper 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 camper self-administer the emergency medication? yes no

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

Safe Snacks	Unsafe Snacks

C. General Information

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

Can the camper 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 camper. 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 Camp 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

Camper 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

- Are there triggers/warning signs? _____

- How will the camper respond/ behave once the seizure is over? _____

History & Management of Seizures:

- When was the camper’s last seizure? _____
- Has the camper been hospitalized for continuous seizures? yes no
- Does the camper have a Vagus Nerve Stimulator (VNS)? yes no
 B. Describe use of the magnet: _____

- Does the camper 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
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no

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

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

If the camper 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 camper. 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 Camp 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

G-tube Feeding Plan & Emergency Action Plan

Supplemental Form

Camper Name: _____ Date: _____

TYPE OF TUBE

1. **What type of tube does the camper have:** Nasogastric Orogastric
 Gastrostomy Percutaneous Endoscopic Gastrostomy Jejunostomy

2. **Does the feeding tube have more than one port?*** Yes No

**If yes, each port must be clearly labeled so that we are aware of which one is for medication, which one is for feeding, and which one is to inflate the balloon.*

MEDICATION ADMINISTRATION

3. **Will the camper require medication administration through their tube during CampAbility?**

Yes No (If yes, please continue below. If no, skip to question 4).

A). If a non-liquid medication, how should this medication be administered?

Crushed Dissolved in water Other: _____

B). If multiple medications, can the medication be administered all together?

Yes No

C). Does the camper require a water flush after medication administration?

Yes No; If yes, please explain: _____

FEEDING INSTRUCTIONS

4. The camper has a doctor's order and is on a specific feeding schedule which will require a feeding during CampAbility yes no (If yes, please continue below. If no, please skip to question 5).

A). What type of formula feeding does the camper consume? _____

B). How much of the formula should be given to the camper? _____

C). Does the camper require a water flush after a feeding?

Yes No; If yes, please explain: _____

D.) Should we expect to have difficulties with the tube clogging? Yes No

If yes, please explain how to unclog the tube: _____

EMERGENCY CARE INSTRUCTIONS

5. If we see drainage around the g-tube area, how should we care for and clean the affected area? (check all that apply and explain below)

- Soap & water
- Ointment
- Other: _____
- Antiseptic solution
- Cover with g-tube gauze

Please explain: _____

5. Should the g-tube happen to come out during camp, how long can the tube be out before the stoma closes up?

A). Please list the procedures we should follow if the g-tube comes out during camp..

If the campers g- tube falls out, please follow the procedures below:	Call 911 immediately if...
1.	
2.	
3.	

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed camper. I agree to train the Respite staff on the care and feeding of the camper listed above. 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 Camp 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

Frequently Asked Questions

What should the camper bring to camp?

- Extra change of clothes (or two!)
- A pair of long pants
- Diapers, pull-ups, or extra underwear; wipes
- Sunscreen, swim diaper, swimsuit, towel, sandals (for water play)
- A sack lunch – we do have access to a refrigerator
- A cup – if a special one is needed for drinking
- A snack (if your child has specific dietary restrictions)
- Medication - be sure to notify staff if medications are needed
- Sensory toys/chewable toys (if needed)
- Communication device (if applicable)

What should the camper wear to camp?

- Comfy clothes – shorts, light t-shirts, etc.
- Camp shirt – on field trip days only
- Gym shoes / closed toed shoes
- It gets chilly at times in our classrooms! An extra sweater or sweatshirt is also recommended!

Will there be an open-house where my child can meet the staff and see their classroom?

Yes! We have scheduled an open house on Thursday, June 7th from 5-6 at the camp site where you have registered. Bring your child and show them their classroom, introduce them to staff and get the camp calendar so you will know what fun-filled activities we have scheduled! ☺

'Typical' camp schedule:

9:00-9:30: welcome / circle time

9:30-10:30: exercise time / gross motor activities

10:30-11:30: water play

- we have small swimming pools (less than 2 ft deep), water slides, sprinklers and water toys

11:30-1:00: lunch and recess

1:00-2:30: stations

- arts and crafts
- snack time
- circle time

2:30-3:00: home rooms for play / prepare to go home

Sick policy:

We want to ensure that all children that come to camp are healthy and free of illness so that others do not get sick. Children attending camp must be free from fever, vomiting, and/or diarrhea for 24 hours. In addition, children must be not present with a contagious illness. Should your child be ill, please contact Angie Hilligoss at 317-466.2001 x 2420. Additionally, if your child becomes ill while with us at camp, we will contact you to arrange pick-up.