CampAbility

presented by easterseals Crossroads

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 family member 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) which 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 30, 2019.**

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

☐ MANDATORY FORMS:

2019 CampAbility Registration Form ..... Pages 2-6
Authorization to use Likeness or Information ..... .Page 7
Reservation and Payment Information ..... Page 8
Agape Therapeutic Riding Facility
- Parent Guardian Release Agreement/Photo Release ..... Page 9-10
- Liability Waiver.....Page 11-12
- Health History .....Page 13-14
- Physician's Statement (requires doctor signature) ..... Page 15

☐ SUPPLEMENTAL FORMS:

Physician's Medication Administration Form (requires doctor signature) .....Page 16
Before and After Care Form ..... Page 17
Scholarship Application Form ..... Page 18
Special Preparation & Food Allergy Plan ..... Page 19-20
Seizure Action Plan ..... Page 21-22
G-Tube Action Plan ..... Page 23-24
FREQUENTLY ASKED QUESTIONS ..... Page 25

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

Easterseals Crossroads Attn: Emily Garvin
4740 Kingsway Drive, Indianapolis, IN 46205
Phone: 317.466.1000 | Fax: 317.788.4640
Email: egarvin@eastersealscrossroads.org

2019 CampAbility Registration

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

PARTICIPANT INFORMATION

First Name:_____ Last Name:_____

Birth Date:___/___/____ Age:_____ Sex:____ Weight:_____ Height:_____

Primary Diagnosis: _____

Secondary Diagnosis:_____

Your participant'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: _____

3. Name: _____ Relation to participant: _____

Home Number: _____ Cell Phone Number: _____

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 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 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 participant.*

Parent/Guardian Signature: _____

Date: _____

PARTICIPANT HISTORY

To be completed by participant'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 PARTICIPANT 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 PARTICIPANT HAS FEEDING TUBE PLEASE FILL OUT G-TUBE FEEDING SUPPLEMENTAL FORM

Communication: (check all that apply)
☐Participant 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 participant should **not** participate in? ☐ YES ☐ NO

If yes, list:
_____

Swimming:
Can Participant 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 participant's behavior:

Bright lights/Sunlight Smells 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:

_____

_____

_____

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: _____
☐ Writing skills: _____
☐ Math skills: _____

Does your participant attend school: ☐ YES ☐ NO Grade Enrolled *(if applicable)* _____
Is the participant in a special education class? Yes ___ No ___ Other _____
Does the participant have an IEP and/or behavior plan? Yes___ No___ **COPY OF CURRENT IEP MUST BE PROVIDED**
Does the participant have a 1 on 1 aide at school? Yes____ No____
If yes, in what capacity does the aide assist participant?

_____
_____

Does the participant have a nurse? Yes____ No_____
If yes, in what capacity does the nurse assist the participant?

_____
_____
_____
_____
_____
_____

Therapy:
Does the participant receive therapy services? ☐ YES ☐ NO

If yes, what type of therapy does the participant receive?
☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Other (Please explain below)

_____
_____

Are there any specific skills the participant has been working on, or any recommendations from therapist that would benefit the participant 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

Participant Name: _____ Date:_____

Cost: CampAbility costs $300 per session ($199 early bird special if registration is received between January 17 and February 28, 2019).

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 participant to attend and which sessions:

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

☐ **Session 1:** June 10 – June 20 (Mondays – Thursdays)

☐ **Session 2:** June 24 – July 3 ***PLEASE NOTE: THE 1st WEEK OF SESSION 2 WILL RUN MONDAY-THURSDAY AND THE 2ND WEEK WILL RUN MONDAY-WEDNESDAY DUE TO THE 4TH OF JULY HOLIDAY**

☐ **Session 3:** July 8 – July 18 (Mondays – Thursdays)

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: _____ CCV Code: _____

_____ _____

Cardholder's Printed Name Cardholder's Signature

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

AGAPE
UNBRIDLED HOPE

Mailing Address for all locations: Agape Headquarters, PO Box 207, Cicero, IN 46034
Fax for all locations: 317-984-9103/ Headquarters phone: 317-773-7433
For more information or to complete an electronic version of this form, please visit our website:
WWW.AGAPERIDING.ORG

PARTICIPANT REGISTRATION PACKET FOR:_____
(Name of Participant)

SECTION I. PARTICIPANT INFORMATION

Preferred Agape Location (Select one):
❒North in Cicero ❒ South in Martinsville ❒ East in Greenfield

Date of Birth: ___/___/___ Age: _____

Address: _____ City/State: _____

County: _____ Zip: _____ Ethnicity: _____ Gender: M/F

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Preferred method of communication: ❒Mobile Phone ❒Home Phone ❒Email ❒Other:_____

Place of Employment: _____

Are you presently a student? Yes/No If yes, name of school: _____

SECTION II. ADULT/GUARDIAN PARTICIPANT INFORMATION IF PARTICIPANT LISTED IN SECTION 1 IS UNDER THE AGE OF EIGHTEEN (18) OR UNDER A LEGAL DISABILITY

Name: _____ Father/Mother/Guardian

Address: _____ City: _____ State: ___ Zip: _____
(If different from participant)

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(If different from participant)

Place of Employment: _____ Email Address: _____

Please name any caregivers/phone numbers who may transport or be responsible for participant:

SECTION III. 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.

_____ Date: _____

SIGNATURE of Participant or Parent/Guardian

SECTION IV. EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Participant: _____
(Primary Contact)

Telephone Numbers: _____

Name: _____ Relationship to Participant: _____
(Secondary Contact)

Telephone Number(s): _____

Primary Physician Name/Telephone Number(s): _____

Preferred Medical Facility: _____

Health Insurance Provider: _____ Policy/Identification Number: _____

Information for Emergency Medical Providers: _____
(Such as allergies, medications, preexisting medical conditions)

Agape Emergency Medical Policy

In the event emergency medical aid/treatment is required for a Participant, Agape Therapeutic Riding Resources, Inc. will:

1. Contact 911, state the nature of the emergency and request that an ambulance be sent to the scene of the occurrence;
2. Contact the person(s) listed above in the priority listed; and
3. Provide the information listed above to emergency medical providers.

I have read and acknowledge the Agape Emergency Medical Policy.

_____ Date: _____

SIGNATURE of Participant or Parent/Guardian

SECTION V. LIABILITY

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. <u>Complete Agreement, Choice of Law, Venue and Attorneys Fees</u>. 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.

<u>ADULT/GUARDIAN(S) FULL NAME</u>

_____
SIGNATURE and Date

_____
Printed Name

_____
SIGNATURE and Date

_____
Printed Name

EACH PARTICIPANT UNDER THE AGE OF 18 OR UNDER A LEGAL DISABILITY FOR WHOM EACH ADULT IS SIGNING:

_____
Participant Name

_____
Participant Name

_____
Participant 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.

SECTION VI. HEALTH HISTORY

PARTICIPANT INFORMATION

Participant Name: _____

Diagnosis/Disability (Required): _____ Date of Onset (if applicable): _____

Height: _____ Weight: _____

DIAGNOSIS & CONDITIONS

If the answer to any of the following health questions is yes, a Physician's Release form (p.7) is required.

Yes	Condition	Date	Details
	Down Syndrome		
	Spinal condition (i.e. injury, scoliosis, fusion, Spina Bifida)		
	Brain condition (i.e. Cerebral Palsy, stroke)		
	Bleeding or clotting disorders		
	Diabetes		
	Fatigue & Immune Deficiency		
	Joint & bones complications (i.e. hip dysplasia, arthritis)		
	Epilepsy		
	Muscular		
	Heart condition		
	Neurological condition		
	Pulmonary condition		
	Skin break down or pressure sores		

In the past 12 months, has the participant been treated for any of the following? If yes, check the box, provide date of occurrence and details:

Yes	Condition	Date	Details
	Hospitalization for any serious injury, condition or surgery?		
	Experienced loss of consciousness, including seizures?		
	Experienced a psychotic crisis?		
	Need assistance to maintain an upright sitting position or control of his/her head?		
	Been necessary to restrict activities due to medical reasons?		
	Does the participant have crutches?		
	Does the participant have a walker?		
	Does the participant have a wheelchair?		
	Does the participant have a G-tube?		

	Does the participant have a catheter?		
	Does the participant have a shunt?		

GENERAL HEALTH AND FUNCTION

Please describe any conditions or issues in the following areas:

	Details
Hearing	
Vision	
Speech	
Circulation	
Cognitive Development	
Emotional or psychological	
Behavior	
If the participant uses an Epi-Pen, please describe when it is needed.	
Please describe any incidents of asthma and causes of asthma.	
If the participant uses an inhaler for any reason, please describe when it is needed.	
Other	

Please list if applicable:
Medications_____

Medical devices (feeding tubes, shunts, etc.)_____

Allergies_____

Tetanus Shot No Yes Date of Shot_____

SIGNATURE

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

Name of person completing this form: _____Date:_____

SIGNATURE: _____Relationship to Participant: _____

Mailing Address for all locations: Agape Headquarters, PO Box 207, Cicero, IN 46034
Fax for all locations: 317-984-9103
Headquarters phone: 317-773-7433
To submit this form electronically, please visit our website: **https://agaperiding.org/adaptive-services-intake-form/**

Please return this form by mail/fax to: Agape Headquarters:
PO Box 207, Cicero, IN 46034; Fax (317) 984-9103

PHYSICIAN'S RELEASE FORM FOR AGAPE

This form is **required** if: ❒ Participant has Down Syndrome OR; ❒ If one or more of the health questions of the Health History Form are 'Yes'.

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PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____ Participant Weight: _____

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		

REQUIRED FOR PERSONS WITH DOWN SYNDROME
Annual physical examination should reveal no symptoms of AAL. *****NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI*****
Annual physical examination for AAI: Negative _____
Date of physical exam (must be within 1 calendar year)_____
Doctor's Initials _____

Jarring Toleration:

☐ YES ☐ NO For activities at the horse barn such as horseback riding, can the participant tolerate jarring?

If no, please explain limitations in detail:

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

Participant 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 participant.

Session 1: June 10 - June 20				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 10				
Tuesday, June 11				
Wednesday, June 12				
Thursday, June 13				
Monday, June 17				
Tuesday, June 18				
Wednesday, June 19				
Thursday, June 20				
			TOTAL DUE:	$

Session 2: June 24 – July 3				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 24				
Tuesday, June 25				
Wednesday, June 26				
Thursday, June 27				
Monday, July 1				
Tuesday, July 2				
Wednesday, July 3				
			TOTAL DUE:	$

Session 3: July 8 – July 18				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, July 8				
Tuesday, July 9				
Wednesday, July 10				
Thursday, July 11				
Monday, July 15				
Tuesday, July 16				
Wednesday, July 17				
Thursday, July 18				
			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

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 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?

_____
_____
_____
_____

In cases of severe allergic reaction, CampAbility staff will:

- Call parent/guardian immediately if the participant is showing signs/symptoms of an allergic reaction.
- Call 911 if signs/symptoms of an allergic reaction appear to be severe.
- Administer emergency medication provided by the family, such as Epi-pen, inhaler, Benadryl.
    - 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 camp, so if your loved one has an allergy please be prepared to send a snack with them to camp.

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 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

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 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 participant has a seizure during CampAbility.

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 Utilized at Camp:

- 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 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

Participant Name: _____ Date: _____

TYPE OF TUBE

1. **What type of tube does the participant 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 participant 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 participant require a water flush after medication administration?
☐ Yes ☐ No; If yes, please explain: _____
_____

FEEDING INSTRUCTIONS

4. The participant 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 participant consume?
_____
_____

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

C). Does the participant 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
☐ Antiseptic solution
☐ Ointment
☐ Cover with g-tube gauze
☐ Other: _____

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 participants 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 participant. I agree to train the Respite staff on the care and feeding of the participant 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 participant 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 appicable)

What should the participant wear to camp?

- Comfortable 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. Please come with 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!

Sample **Camp Ability 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 attneding 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 Emily Garvin at 317.466.2001 x 2504. Additionally, if your child becomes ill while with us at camp, we will contact you to arrange pick-up.