

# Camp



# ROCKS

camp for individuals on the autism spectrum

## General Camper Application 2019

Please return completed form to:

Mail  
Bonnie Fisher  
Easterseals Crossroads  
4740 Kingsway Drive  
Indianapolis, IN 46205

Email  
[bfisher@eastersealscrossroads.org](mailto:bfisher@eastersealscrossroads.org)

Fax  
Bonnie Fisher  
317.466.2000



presented by



# APPLICATION INSTRUCTIONS

Please note that this is a global application and some portions of the application may not necessarily apply to your camper, but please fill out each section to the fullest so that we can ensure your camper's spot at camp! We want to ensure we have all the necessary information on your camper.

- ALL application materials in this packet are due by April 30, 2019.
- We encourage you to schedule your child(s) appointment for his/her camp physical with your physician now to assure that these forms are completed by the deadline. Not having these forms could result in your child being put on standby and accepted only if space is available.
- Agape Therapeutic Riding is a separate organization that is housed at Bradford Woods and runs our therapeutic riding program in the summer. We have combined the Agape registration with our Camp ROCKS application, including our physician's release. It will now work for both Agape and Camp ROCKS.
- Please return ALL application materials via mail, email or fax:

Bonnie Fisher  
Easterseals Crossroads  
4740 Kingsway Drive  
Indianapolis, IN 46205

Email  
[bfisher@eastersealscrossroads.org](mailto:bfisher@eastersealscrossroads.org)

Fax  
Bonnie Fisher  
317.466.2000

If you have any questions or require additional information, please do not hesitate to call Bonnie Fisher at 317.466.1000 x2488 or email at [bfisher@eastersealscrossroads.org](mailto:bfisher@eastersealscrossroads.org)

Please keep a copy of ALL application materials for your records!

# CAMPER INFORMATION

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Goes By: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Degree:  Slight  Moderate  Severe

Secondary Diagnosis: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Degree:  Slight  Moderate  Severe

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

**YOUTH** -  SMALL  MEDIUM  LARGE

## PARENT/ GUARDIAN INFORMATION

CAMPER IS HIS/HER OWN GUARDIAN:  YES  NO

### 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

When is the best time to reach you?  Morning  Afternoon  Evening  Other \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Marital Status: \_\_\_\_\_

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### 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

When is the best time to reach you?  Morning  Afternoon  Evening  Other \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Marital Status: \_\_\_\_\_

**In case of an emergency, if the parent/guardian cannot be reached, please contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

# CAMPER MEDICAL HISTORY

To be completed by camper's parent/guardian; please print clearly.

Camper's Biological Sex: \_\_\_\_\_

**Diet:**  Typical  Blended/Pureed  Gluten Free  Vegetarian  Diabetes  
 Other

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

**Seizures:**  YES  NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Describe any warning signs before seizures: \_\_\_\_\_

What steps are taken at home once your camper has a seizure? \_\_\_\_\_

Is your camper medicated for seizures?  YES  NO Date of last seizure: \_\_\_\_\_

**Allergies:** (Check all that apply)

None  Pollen  Poison Ivy  Latex  Animals  Bee/Insects  Food  
 Medications  Peanuts  Other \_\_\_\_\_

If allergic to medications or food, please list:

Describe any allergic reactions: \_\_\_\_\_

**Respiratory:** (Check all that apply)

Tracheotomy  CPAP  BiPAP  Nebulizer  Other \_\_\_\_\_

If so, describe: \_\_\_\_\_

**Bowel:**

How frequent are your camper's bowel movements?  Daily  Every Other Day  Once a Week  
 Twice per Week  Three Times per Week  Other \_\_\_\_\_

Do your camper's "bathroom habits" change in different environments?  YES  NO

Explain: \_\_\_\_\_

Does your camper wear diapers/ briefs/depends?  YES  NO

Explain: \_\_\_\_\_

**Feminine Needs:**

Does your camper menstruate?  YES  NO

Do you have any special treatment for cramps? \_\_\_\_\_

List feminine products used and if assistance is needed: \_\_\_\_\_

**Camp Activities:**

General Camper Application 2019 for \_\_\_\_\_

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)

Does your camper experience a pain crisis after swimming?  YES  NO

**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 yes, what type of assistance is needed? Any special instructions \_\_\_\_\_

**Sleeping Behavior:**

Typical sleeping habits  Has trouble going to sleep  Has nightmares  Wets bed

Sleep walks  Runs Away

Special routine \_\_\_\_\_

Usual bedtime \_\_\_\_\_ Usual wake up time \_\_\_\_\_

**Hospitalizations:**

Please list recent surgeries (*within the last 12 months*): \_\_\_\_\_

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

**Physical Health History:**

Conditions	YES	NO	If yes, please explain
Back Problems			
Clotting			
Dizziness/Passing Out			
Heart Murmur			
HIV			
Joint Problems			
Mono ( <i>within in last 12 months</i> )			
Skin Problems ( <i>itching, rash, etc.</i> )			
Bleeding			
Chest Pain			
Head Injury			
High Blood Pressure			
Immunodeficiency			
Lice			
Shunt ( <i>indicate side</i> )			
Diabetes			
Asthma			
Visual Impairment			

**Medications:**

Please indicate the **total number** of medications your camper is taking, including prescription, over-the-counter medications, supplements, vitamins, etc.: \_\_\_\_\_

**Dates of Immunizations:**

Measles, Mumps, Rubella: \_\_\_\_\_ Tetanus-diphtheria Toxoid: \_\_\_\_\_ H. Influenza: \_\_\_\_\_

Pneumonia: \_\_\_\_\_ Last TB Skin Test: \_\_\_\_\_ Results: \_\_\_\_\_

DPT Series: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_ 5) \_\_\_\_\_

Polio Series: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ Chicken Pox: 1) \_\_\_\_\_

Hepatitis B: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

# CAMPER MENTAL, SOCIAL, AND EMOTIONAL HEALTH

## Family Changes and Homesickness

Yes

No

Has the applicant gone through any significant family changes? (death, divorce, adoption, abuse, etc.)

If yes, please describe.

Are you concerned about the applicant's ability to cope with homesickness? If yes, please explain why.

## Mental, Emotional, and Social Health History

- |  |  |
|--|--|
| <input type="checkbox"/> Attention Deficit Disorder (ADD or AD/HD)       | <input type="checkbox"/> Depression                        |
| <input type="checkbox"/> Obsessive-Compulsive Disorder                   | <input type="checkbox"/> Panic, Anxiety Disorder           |
| <input type="checkbox"/> Eating Disorder                                 | <input type="checkbox"/> Substance Abuse                   |
| <input type="checkbox"/> Learning or Processing Challenge                | <input type="checkbox"/> Self-harming or Suicidal Ideation |
| <input type="checkbox"/> Suspended or Expelled from School               | <input type="checkbox"/> Personality Disorder              |
| <input type="checkbox"/> Other Mental, Emotional, or Social Health Issue |  |

**\*\* We are asking for this information to help us better serve your camper while at camp. Please note that indicating these does not necessarily preclude your camper from attending camp. \*\***

For each mental, emotional, or social health concern indicated on the previous page, please provide details on the treatment of the condition and the effect (if any) it will have on their experience at camp by using the questionnaire on the next page. If no indication is made, please write DOES NOT APPLY in the boxes below.

**Concerns**

**Yes      No**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Has the applicant received professional treatment for this issue?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the applicant currently taking prescription medication for this issue?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the applicant gone through any significant family changes? (death, divorce, adoption, abuse, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

**Management Regimen**

What are some management techniques that are used to manage this issue?

**Indication of Change in Mental Health Status**

List behaviors that would indicate your child's emotional state is fluctuating (i.e. your child is becoming irritated, depressed, overwhelmed, etc.)

Does your camper have emotional outbursts?  YES  NO

What seems to trigger the outburst? \_\_\_\_\_

During an outburst, what is normally done at home to calm him/her down?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# GENERAL INFORMATION

**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.)?

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**Communication:**  No serious difficulties expressing thoughts or wants  Has difficulty  
 Uses Sign Language  Uses a communication device  PEC Board  
 Uses non-verbal communication  Hearing impaired; partial or total: \_\_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_

**Education:**  Reading skills: At what level? \_\_\_\_\_  
 Writing skills: At what level? \_\_\_\_\_  
 Math skills: At what level? \_\_\_\_\_

Does your camper attend school:  YES  NO  GRADUATED Grade Enrolled (*if applicable*) \_\_\_\_\_

What age level does your camper function within a social context? (Indicate months/years with age) \_\_\_\_\_

Is your camper in a special education/life skills class? Yes \_\_\_ No \_\_\_ Other \_\_\_\_\_

**Camper Likes:** Please list any activities, foods, noises/music, etc. that your camper likes, or that help your camper to relax

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**Camper Dislikes:** Please list any activities, foods, noises/music, etc. that tend to agitate or upset your camper

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**Travel:** Please list any alternate family or friends that have permission to pick up your camper up from camp. Individuals not listed will NOT be allowed to pick up your camper.

<i>First Name</i>	<i>Last Name</i>	<i>Relation to camper</i>	<i>Cell phone number</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## PERSONAL CARE & SKILLS

Please indicate if your camper can perform the requested skill **independently** and/or if any assistance is needed. If assistance is needed, please explain. **PLEASE PRINT.**

PERSONAL CARE	INDEPENDENTLY	NEEDS ASSISTANCE	EXPLANATION OF ASSISTANCE	N/A
Uses the toilet				
Washes hands and face				
Brushes teeth				
Takes a shower				
Combs/brushes hair				
Dresses self: Underwear/brief				
T-shirt/jacket				
Pants/shorts				
Shoes & socks				
Other				

MOBILITY/FINE & GROSS MOTOR SKILLS	INDEPENDENTLY	NEEDS ASSISTANCE	EXPLANATION OF ASSISTANCE	N/A
Supports self while sitting				
Operates own wheelchair				
Transfers from seat to chair/ from bed to chair				
Uses crutches/walker				
Can roll over in bed				
Grasps and releases objects				
Other				

MEALTIME NEEDS	INDEPENDENTLY	NEEDS ASSISTANCE	EXPLANATION OF ASSISTANCE	N/A
Can feed self with fork/spoon				
Can feed self with finger food				
Can swallow whole foods				
Can hold cup or glass				
Can use adaptive utensils				
Can identify when full				
Can drink through a straw				
Other feeding instructions				

<b>BEHAVIORS:</b>	Has your camper ever displayed the following? Please check for each			<b>Explanation</b>
Hitting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Pinching	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Hair Pulling	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Biting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Kicking	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Spitting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Scratching	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Bullying	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Stealing	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Lying	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Swearing	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Wandering	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Withdrawal	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Impulsivity	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Non-compliance	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Mood swings	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Verbal Threats	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Throwing Objects	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Hand Flapping	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Head Banging	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Rocking	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Inflicts self-injury	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Disrobing	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Anxiety/depression	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Sexual acting out	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Genital stimulation	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	
Suicidal ideation	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	

If there are any additional comments, concerns, medical or behavioral information we need to know about in order to better serve your camper please list here: \_\_\_\_\_

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# RECREATION THERAPY CAMPER ASSESSMENT

Camper: \_\_\_\_\_ Camp Name: \_\_\_\_\_

**Camp Goal:** (Identify one goal the camper would like to accomplish at camp)

Please *circle* the description that best represents the camper and write in additional comments

**Does your camper have sensory stimulation needs?**

Yes

No

Low Sensory Need

Moderate Sensory Need

High Sensory Need

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Healthy Leisure Lifestyle** (how active is the camper in recreation activities and hobbies)

Low Participation

Moderate Participation

High Participation

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Independence (in home setting)**

Displays Low Independence

Displays Moderate Independence

Displays High Independence

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Social Skills (outside of camp)**

Avoids Social Interactions

Tolerates Social Settings

Actively Engages in Social Interactions

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Friendships (outside of camp)**

Has few or no friendships

Has some friendships

Has many friendships

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Social Acceptance (outside of camp)**

Doesn't feel accepted by peers

Feels somewhat accepted by peers

Feels accepted by peers

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Physical Activity Level (outside of camp)**

Low Participation

Moderate Participation

High Participation

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Opportunity to be with other youth that have the same diagnosis (outside of camp)**

Never

Sometimes

Often

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

**Frustration Tolerance**

Low Frustration Tolerance

Moderate Frustration Tolerance

High Frustration Tolerance

1

2

3

4

5

Areas for improvement: \_\_\_\_\_

# INSURANCE

Is your camper covered by hospitalization insurance?  YES  NO

Carrier: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

A copy of your camper's insurance, Medicaid or Medicare card is required. Please supply a copy of BOTH the FRONT and BACK of the card. Please provide a current picture of your camper that mainly shows his/her face.

**COPY of Front of Insurance  
Card**

**COPY of Back of Insurance  
Card**

**Recent Photograph of  
Your Camper**

## FORMS AND RELEASES

Please read the following information closely, it will outline all of the following forms, when they need to be submitted, and what they entail.

**Agape Therapeutic Horseback Riding** – This form has some additional information needed in order for your camper to attend Agape during their camp session.

**Teacher Consent Form** – this form is required for all campers applying to Camp ROCKS. Please have the teacher fill out and complete this form. This form can be sent with the application.

**Camp ROCKS Assumption of Risk and Release** – this is the general Camp ROCKS release from liability, please read carefully before signing the form. This form should be sent with the application and is to be filled out by the camper, if your camper cannot sign, please sign as their guardian.

**Demographics Form** – this form is used by Bradford Woods and ROCKS Children’s Foundation to offer financial assistance, camperships, and for grant and donor support reports.

**Caring for Your Camper** – this forms give you information on some of the care that our staff will be providing while your camper is at camp and in the cabins. It covers topics such as skin checks, transfers, hygiene, personal care, and level of assistance. This form should be sent with the application.

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**Camp ROCKS Physician’s Release** – this form it to be completed by a physician and is required in order for your camper to be accepted into camp. Please make sure that your physician lists any activities that you camper *cannot* participate in and for our campers with Down syndrome, we require a current AAI Exam within the past year. This form can be sent after the application packet but will not be officially accepted into camp until it is received by Bradford Woods staff.

**Agape Registration Packet and Physician’s Release** – this packet is the registration for Agape Therapeutic Horseback Riding. Please keep in mind that **all campers** need to have the physician’s release completed regardless of previous answers. Agape also requires a current AAI Exam within the past year for campers with Down syndrome. This form can be sent after the application packet but will not be officially accepted into camp until it is received by Bradford Woods staff.

**Adapted Scuba RSTC Medical Form with Physician’s Release** – this form is required for our and will need a physician’s signature. Please fill out the first page and the first part of the second page on your own, and have your physician complete the bottom half. This form can be sent after the application packet but will not be officially accepted into camp until it is received by Bradford Woods staff.

# 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **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

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Signature and Date

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Name

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

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Signature and Date

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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.

General Camper Application 2019 for \_\_\_\_\_

# TEACHER CONSENT

**Note to Teacher:** The following information is extremely important to help Bradford Woods staff and the IU Health Camp medical team determine the best cabin placement for the child. Please be specific so Camp ROCKS can provide the best camping experience possible for your student.

Camper's Name: \_\_\_\_\_

Camper's School: \_\_\_\_\_

School Address: \_\_\_\_\_

\_\_\_\_\_

Teacher(s) Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

At what age level is the child functioning?  
(Indicate months/years with age) \_\_\_\_\_

At what age level is the child functioning within a social  
context? (Indicate months/years with age) \_\_\_\_\_

Is the child in a special ed/life skills class? Yes \_\_\_ No \_\_\_  
If so, what type? \_\_\_\_\_

Please describe child's receptive communication ability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe child's expressive communication ability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain specific behavioral difficulties and  
successful management techniques, if any.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What level of personal care does child receive at school  
(mobility, feeding, toileting, number of people required  
to assist, etc.)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this child have a 1:1 aide in the classroom?  
Yes \_\_\_ No \_\_\_

If yes, what is the aide's focus (e.g. academic support,  
physical assistance, behavioral support)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To best support the camper in an accessible outdoor  
environment, what staff-to-child ratio would you  
suggest?

1:1 \_\_\_ 1:2 \_\_\_ 1:3 \_\_\_ 1:4 \_\_\_ 1:5 \_\_\_

Please briefly explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **For campers applying to Venture (Beyond the Woods):**

Please tell us about the child's strengths and academic  
goals. What skills will he/she need to be successful in  
post-secondary education?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Teacher's Signature**

# Medication Consent and Review

Camper Name \_\_\_\_\_

Camp Session \_\_\_\_\_

## NON-PRESCRIPTION MEDICATION CONSENT

While participating in CRC Camping Programs at Bradford Wood, I give permission for the person listed above to receive nonprescription medications, as deemed necessary by camp medical staff and as directed by the manufacturer of the specific medication.

These will include, but are not limited to, the medications listed below.

Please note that generic substitutes may be used.

### *For Aches and Pains:*

Tylenol (acetaminophen), Ibuprofen

### *For Itching and Allergies:*

Benadryl, Benadryl Cream, Caladryl Lotion

### *For Nasal Congestion:*

Sudafed, Robitussin

### *For Upset Stomach:*

Maalox, Pepto Bismol, Milk of Magnesia, Tums

### *For Constipation:*

Milk of Magnesia, Laxatives (Mineral Oil or Miralax), Glycerin Suppository, Enema

### *For Diarrhea:*

Imodium

Comments/Exceptions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Camper Application 2019 for \_\_\_\_\_

List of Non-Prescription Medications Camper  
Brought to camp:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Guardian Signature

\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Nursing Staff Signature

\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## MEDICATION REVIEW

I have reviewed the Health and Medication Record for the person named above and have discussed and shared information concerning medications, allergies, medication administration procedures, and adverse effects with a member of the nursing staff at Bradford Woods. I agree that the medication information and medication schedules appear correctly on the Health and Medication Record.

Legal Guardian Signature

\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Nursing Staff Signature

\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_



## Caring for Your Camper

Dear Parents and Caregivers,

Our goal is to provide excellent care to every camper. While your camper's medical needs will be handled by the camp's medical staff (IU Health nurses or physicians for ROCKS camps, or other nurses and physicians hired by non-ROCKS camps), Bradford Woods staff members assist in and provide camper care throughout your child's stay. Bradford Woods staff members are trained in personal care; behavior management; and emergency procedures and aim to provide the least restrictive assistance needed for each individual camper to promote independence and autonomy. Additionally, Bradford Woods staff members (hereafter referred to as "staff members") are trained to respect the privacy of each camper without compromising safety. The following procedures and personal care practices may be relevant to your child while at camp.

### Transfers

Staff members are trained to use the front-to-back, two-person transfer, but will also ask if a camper needs or prefers another style. Staff members are also trained on the side-to-side, two-person transfer, and a one person "bear hug"/pivot transfer.

### Hygiene

Campers typically brush their teeth twice daily – once in the morning and once in the evening. Staff members will follow any instructions regarding specific morning or nighttime routines (retainers, face wash, specific lotions, etc.). If a camper would like to shave throughout the week, he or she must either do it independently or bring an electric device to use with assistance as needed.

### Showering and Bathing

Campers are required to shower/bathe at least twice throughout the week, but most will shower at least every other day. All of our cabins have shower stalls (with accessible shower chairs), but there are bathtubs available in a few of the cabins if needed. For campers who require assistance showering/bathing, cabin staff members will assist to the degree appropriate for each camper.

### Toileting

Bathroom facilities are available in each cabin and at or near all program sites. These facilities are fully accessible and contain matted areas for campers who use depends and/or briefs. If your camper has a specific bathroom or changing schedule, the cabin staff will make note of that schedule and ensure that it is followed. All campers who require toileting assistance will be

cleaned in a timely manner when the need arises. Additionally, bowel movements and voids will be tracked for medical purposes for campers who require it and/or as directed by the camp's medical staff.

### Skin Checks

Under the direct supervision of a physician or RN, cabin staff members will conduct skin checks within 24 hours of a camper's arrival, and again during the last two days of camp. These checks are documented and kept with a camper's medical file once he or she leaves camp. Skin checks are conducted to look for skin irritations, insect bites, ticks, sunburn, blisters, pressure sores, and/or any skin breakdown that may need to be addressed. The extent to which staff members conduct the skin check will depend on the physical and intellectual abilities of each camper.

### Cabin Paperwork

Cabin staff members will document activities of daily living and personal care procedures for each camper as appropriate. Such activities and personal care procedures include: showers, bowel movements, and urination. In addition, staff members will document how well a camper ate throughout the day, if the camper was staying hydrated, and the camper's interactions in the cabin with both peers and staff members. A daily report will be provided to parents at checkout.

### Level of Assistance

Staff members will provide a level of assistance appropriate to the camper's physical and mental needs. For example, campers with involved physical disabilities may need close to 100% assistance with activities of daily living and care, while others may be 100% independent. The least restrictive environment will be implemented to ensure the highest level of independence possible.

### Parent/Guardian Acknowledgment and Consent:

I have read, fully understand, and agree that the above personal care practices and/or procedures may be relevant to my child while he/she attends camp, and I consent to all such personal care practices and/or procedures.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

General Camper Application 2019 for \_\_\_\_\_

# Physician Release for Camp ROCKS 2019

This form must be filled out and signed by a PHYSICIAN before being returned to Bradford Woods.

Your camper will not be officially accepted into Camp ROCKS until Bradford Woods has received this form. This form is due NO LATER than April 30, 2019

To my knowledge, there is no reason why this person cannot participate in horseback riding, recreational activities, waterfront activities (swimming/canoeing/water skiing/fishing/boat rides), music therapy, arts and crafts, archery, and high ropes initiatives (rock wall/zip line). However, I understand the Bradford Woods will evaluate the medical information that has been provided in relation to the existing Bradford Woods's precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc), in the implementation of an effective equine activity program.

Camper may participate in all camp activities excluding:

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Jarring Toleration:

YES  NO For activities at the horse barn such as horseback riding, can the camper tolerate jarring? If no, please explain: \_\_\_\_\_

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Name/Title (please print) \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

## FOR PERSONS WITH DOWN SYNDROME

Atlantoaxial Instability (AAI) Exam *is required* prior to entering Agape Therapeutic Riding Center at Bradford Woods.

*This neurological exam must be completed within one calendar year of Camp.*

Annual examination should reveal no symptoms of AAI. X-ray NOT REQUIRED or accepted in place of annual physical exam.

\*\*\*NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI\*\*\*

Annual physical examination for AAI: Negative \_\_\_\_\_

Date of Exam (must be after August of previous calendar year): \_\_\_\_\_ Physician's initials: \_\_\_\_\_

General Camper Application 2019 for \_\_\_\_\_



taking on disability together

## Camp ROCKS Payment Options

Please select the appropriate options for your payment

**Camper's Name**

**Required \$100.00 Deposit**

\_\_\_\_\_ Check enclosed

\_\_\_\_\_ Please charge my credit Card the \$100 deposit

\_\_\_\_\_ Please charge my credit card the full cost of the camp \$375.00

---

**Printed Name**

---

**Card Number**

---

**Expiration Date**

---

**CSV (3-digit code on back of card)**

---

**Signature**

If you are interested in applying for a scholarship please attach a copy of your 2017 tax return.

Scholarship recipients are still required to pay a \$100.00 deposit.

General Camper Application 2019 for \_\_\_\_\_

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Parent/Guardian Name

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Parent/Guardian Signature Date

General Camper Application 2019 for \_\_\_\_\_

## **APPLICATION REMINDER**

**All application materials are due by April 30, 2019**

Please mail all application materials to the address below.

Bonnie Fisher  
Easterseals Crossroads  
4740 Kingsway Drive  
Indianapolis, IN 46205

For any questions please contact us at 317.466.1000 x2488

We are looking forward to serving you and your camper this summer at Camp ROCKS!

*Please keep this page and all previous pages for your records!*