Camp ROCKS

camp for individuals on the autism spectrum

General Camper Application 2019

presented by easterseals Crossroads

Please return completed form to:

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

Email
bfisher@eastersealscrossroads.org

Fax
Bonnie Fisher
317.466.2000

BRADFORD WOODS

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

  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

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 Numbe:r (_____) _____ Type: ☐ Mobile ☐ Home ☐ Work

When is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening ☐ Other _____

Relationship to camper: _____

Marital Status: _____

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:

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 you 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 *(within in last 12 months)*			
Skin Problems *(itching, rash, etc.)*			
Bleeding			
Chest Pain			
Head Injury			
High Blood Pressure			
Immunodeficiency			
Lice			
Shunt *(indicate side)*			
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

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

**** 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?	☐	☐
Is the applicant currently taking prescription medication for this issue?	☐	☐
Has the applicant gone through any significant family changes? (death, divorce, adoption, abuse, etc.)	☐	☐

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.)?

_____
_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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.

First Name Last Name Relation to camper Cell phone number

_____
_____
_____

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				

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

_____

_____

_____

_____

_____

_____

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.

- - - - -

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

_____

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.

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?

_____
_____
_____
_____

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:

_____

_____

_____

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

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:
_____
_____
_____
_____
_____

Jarring Toleration:
☐ YES ☐ NO For activities at the horse barn such as horseback riding, can the camper tolerate jarring? If no, please explain: _____
_____
_____

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 _____

easterseals Crossroads

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 _____

Camper Authorization to use Likeness/Information

Camper 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 release Easterseals Crossroads and its legal representatives, respective employees and agents (the "Releasees") from any liability for any violation or claims relating to said images or video. While Easterseals Crossroads does not generally promote campers or other individuals taking photos or videos with cell phones, I understand that during the typical camp experiences some photos or videos may be taken by fellow campers or other individuals present. I also release the Releasees from any liability for any violation or claims relating to said images or video. If, despite this release, I, the Camper, or anyone on the Camper's behalf, makes a claim against Releasees I agree to defend, indemnify and save and hold harmless the releasees and each of them from any litigation expenses, attorney fees, loss, liability, damage or cost they may incur due to the claim made against any other of the "releasees" named above, whether the claim is based on the negligence of the releasees or otherwise.

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 (HIPAA). As this release relates to HIPAA protected health information, 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 Camper (if 18) or Legal Representative | Date

_____ _____

Printed Name of Camper or Legal Representative | Relationship to Camper

_____ _____

Witness | Date

Main . 4740 Kingsway Drive . Indianapolis, IN 46205 . p/ 317.466.1000
South . 3215 East Thompson Road . Indianapolis, IN 46227 . p/ 317.782.8888
Industrial Services . 8302 East 33rd Street . Indianapolis, IN 46226 . p/ 317.897.7320
easterseals crossroads.org . **crossroadsindustrialservices.org**

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 Riley camps, or other nurses and physicians hired by non-Riley 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.

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_____

Parent/Guardian Name

_____

Parent/Guardian Signature Date

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!