Discovery Club 2019-2020

Dear Family and Child,

We would like to welcome you to Discovery Club! We hope you had a wonderful summer. We are looking forward to a fantastic year!

The enclosed forms *must* be completed and returned by mail *prior* to your child attending Discovery Club. This packet is required of all participants at this time. If you require additional copies, visit the website: http://bit.ly/discoveryclub2019

In addition to the forms, the annual registration fee of $40/child must be submitted with your application. Please write checks payable to **Easterseals Colorado**.

Discovery Club fees for the 2019-2020 year are $35 per child, per session or $60 for 2+ children in the same family, per session. Financial assistance is available; please contact Peggy Brown.

Discovery Club will continue to provide entertainment, arts and crafts, and snacks for each child. You must send a lunch with your child. Sessions will be held Saturdays, 10a.m. to 4 p.m., September to May. A brochure with dates and locations is attached.

On the application, your email address is requested. For session reservations, an email will be sent to you on the Monday prior to the session. Please respond by Wednesday of the week if your child will be attending. Discovery Club is unable to accommodate "drop-ins" or late reservations. For those without email, please provide a phone number by which you can be contacted.

Please use the following checklist to verify that all information has been submitted.

_____ Discovery Club Application
_____ $40 Registration Fee
_____ Copy of Medicaid/Medicare/Insurance Card
_____ Recent Photo of the Child
_____ Participant Health Profile
_____ Immunization Record State Form
_____ Seizure Action Plan (if applicable)
_____ Asthma Action Plan (if applicable)
_____ Severe Allergy Action Plan (if applicable)
_____ Behavioral Modification Plan from the school (if applicable)
_____ Emergency Sheet
_____ Advance Directives (if applicable)
_____ HIPAA Waiver
_____ Authorization for the Administration of Medication -- *1* form for *each* medication to be given at Discovery Club is required. Each child must have one form for sunscreen (unless the child has an allergy or adverse reaction to sunscreen noted in the list of allergies). Without sunscreen a child will not be allowed to play outside.

If you have questions, please free to contact me by phone or email. I would be happy to answer any question you may have regarding Discovery Club.

Peggy Brown, RN, BSN
Discovery Club Coordinator
720.339.7202
pbrown@eastersealscolorado.org

Chris Tyler
Respite Coordinator, Easterseals Colorado
303.233.1666 x 345
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Marlene Evans, RN, BSN
Director of Discovery Club – Northglenn
303.906.8399
m.evansrn@gmail.com

Easterseals Discovery Club Application

Date of Enrollment:_____

Participant Information

Participant Name: _____
First Middle Last

Physical Address: _____

Nickname: _____Date of Birth: _____Gender: _____Ethnicity: _____

Primary Diagnosis: _____

_____

Secondary Diagnosis: _____

_____

Funding Policy
The annual registration fee for Discovery Club is $40. To participate in Discovery Club, $35 per session for 1 child ($60 per session for 2 or more children of the same family) is to be paid at the time the participant is dropped off at the site. I have read and understand the Funding Policy.

☐ **Self-Pay**

☐ **Scholarship**

☐ **Agency Funding** (*MUST fill out fields listed below*)

Agency Name: _____

Case Manager Name: _____

Case Manager Phone Number: _____

Provide documentation if alternative funding, other than self-pay, is used for the participant

_____ _____
Signature of Parent/Legal Guardian #1/Date Signature of Parent/Legal Guardian #2/Date

Medical Insurance

Insurance Name _____ Policy/Group Number _____

Medicaid Number _____ Medicare Number _____

☐ **Provide a copy of the Insurance/Medicaid/Medicare Card to be used for urgent care and/or emergency services only**

☐ **Provide a recent photo for identification of the participant**

Which Discovery Club Site(s) would you like to attend?

☐ Aurora ☐ Boulder ☐ Highlands Ranch ☐ Northglenn

Advance Directives

Do you have advance directives? If yes, please submit a copy.

☐ Yes ☐ No

Parent/Legal Guardian #1 Name:

Physical Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Extension: _____

Email: _____

Employer Information: _____

Parent/Legal Guardian #2 Name:

Physical Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Extension: _____

Email: _____

Employer Information: _____

Is anyone not allowed to pick up the child from Discovery Club?

☐ No ☐ Yes

If yes, please specify: _____
_____
_____
_____
_____
_____

Emergency Contacts
In the event the parent/legal guardian cannot be contacted, an emergency contact will be called. Emergency contacts must show valid picture identification when picking up the child from Discovery Club. Only those people listed below, in addition to the parent/legal guardian, may pick up the child from Discovery Club.

Emergency Contact #1 Name:_____
First Last

Relationship to Participant: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Extension: _____

Address: _____

Authorized to pick up child: Yes____ No ____

Emergency Contact #2 Name:_____
First Last

Relationship to Participant: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Address: _____

Authorized to pick up child: Yes____ No ____

Emergency Contact #3 Name:_____
First Last

Relationship to Participant: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Address: _____

Authorized to pick up child: Yes____ No ____

Pick-Up Policy/ Late Pick-Up Policy/Sick or Behavioral Pick-Up Policy
I understand the participant will only be released from Discovery Club to a Parent, Legal Guardian, or Emergency Contact. An Emergency Contact must have valid picture identification for the child to be released. Participants are to be picked up no later than 4pm. The child may not return to the program if two or more late pick-ups occur during the 9 month Discovery Club year, September to May. Sick participants or participants experiencing behavioral issues must be picked up within one hour of the notification call.

I have read and understand the Pick-Up Policy and will abide by such policy to ensure the safety of all participants.

_____ _____
Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Emergency Sheet

Name: _____ Program/Site: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Allergies (medications, food, and/or environmental). Describe; if none please write no allergies:

_____

_____

Current medications:

_____

_____

List any health conditions that may have implications for emergency care:

_____

_____

Emergency Contact #1: Name/Phone/Address/Relationship:

_____

Emergency Contact #2: Name/Phone/Address/Relationship:

_____

Who should be contacted first in case of an emergency?

Name:_____ #1 Phone:_____ #2 Phone:_____

The undersigned, in case of emergency contacts and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

(Initial)_____

Do you have advance directives? If yes, please submit a copy.

☐ Yes ☐ No

Medical Contact Information:

Doctor Name: _____ Phone Number: _____

Address:_____

Preferred Hospital: _____

Dentist Name: _____ Phone Number: _____

Address:_____

☐ I have voluntarily provided the above contact information and authorize Easterseals Colorado and its Representatives to contact any of the above on my behalf in the event of an emergency.

Signature of Participant/Employee/Volunteer/Legal Representative

_____ Date _____

Program Medical Form

_____ _____
(Participant's Name) (Program/s)

Please return this form **with physician's signature within one week of Program** to:
Discovery Club, 393 S Harlan St, Suite 250, Lakewood, CO 80226. Attn: Peggy Brown

Application will be returned if incomplete. Please note Medical Form is (3) pages in length.

Medical History

1. Are the applicant's immunization records up-to-date and complete? Yes No
   If applicant is under 18 years old, please attach a copy of records.
2. Date of last tetanus shot_____ (Mandatory Information)
3. Has there been any recent exposure to a contagious disease? Yes No
   a. If yes, please explain:
4. How would you assess the applicant's current health? Good Fair Poor
5. List any chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware:
6. Is the applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B? Yes No
   a. If yes, was a lab test conducted to determine the presence of antibodies?
      Yes No
   b. Were antibodies present? Yes No
   c. **Physician's Initials_____**
7. Is the applicant a carrier of any other infectious or contagious condition? Yes No
   a. If yes, please explain:
8. Does the applicant have any known allergies? Yes No
   a. If yes, please describe:
9. Does the applicant have seizures? Yes No
   a. **If yes, please answer the following:**
      Current status (i.e. active, controlled):_____
      Type of seizure, how often: _____

Medications

A complete medication profile is necessary in the event of an emergency. Include all prescribed and over the counter medications the participant may take (even while not attending Discovery Club) including creams, sunscreens, acetaminophen, and ibuprofen.

Medication #1:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #2:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #3:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #4:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #5:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #6:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #7:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #8:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #9:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #10:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #11:_____ Dose:_____

Times given: _____ To be given at Discovery Club? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication Policy
The Discovery Club Nurse may only administer medications under the direction of the participant's physician. All medications must be given to the Discovery Club Nurse for safe storage.

Prescribed medications must be in the original container and include the original pharmacy label.

Over the counter medications (such as diaper creams, sunscreens, Tylenol for headaches, etc.) must be in the original container. A written prescription from the health care provider for the medication must be on file. The medication will be given only for the reason prescribed by the health care provider.

I understand that I must supply Discovery Club with any prescribed or over the counter medications to be given to the participant.

All documented prescriptions from the health care provider will remain valid for the Discovery Club Year, September to May, unless otherwise noted by the health care provider. Medications expired per the manufacturer or pharmacy label cannot be given to the participant. I understand that medication will be destroyed if not picked up within one month following termination of the order or May 31st of the year, whichever comes first.

I have read and understand the Medication Policy and hereby request medications to be administered by Discovery Club personnel.

_____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

PHYSICIAN'S CONSENT AND SIGNATURE

When seen by me on this date, the above named applicant was free from any contagious or infectious diseases or conditions and is capable of participating in the Discovery Club.

Physician Signature:_____ Date:_____

Physician's Name (Please Print):_____

Office Phone:_____ Emergency Phone: _____

_____

Address City State Zip

Authorization for the Administration of Medication at Discovery Club

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication.

Complete *one form* for *each medication* to be administered at Discovery Club, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (*specify*): _____

Medication shall be administered from: _____to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address:_____

_____

Use for Prescriber's Stamp

Prescriber's Signature: _____ Date: _____

Participant Health Profile

Participant Name: _____
First Middle Last

Nickname: _____Date of Birth: _____Gender: _____

Primary Diagnosis: _____

_____

_____

Secondary Diagnosis: _____

_____

_____

Surgeries/Dates: _____

_____

_____

Food Allergies: _____

What Happens: _____

Treatment Required: _____

Environmental Allergies: _____

What Happens: _____

Treatment Required: _____

Medication Allergies: _____

What Happens: _____

Treatment Required: _____

☐ **Provide a copy of the updated immunization record state form**

☐ **Provide a copy of the Individualized Education Plan (I.E.P) if possible.**

Communication/Speech

☐ Verbal ☐ Nonverbal ☐ Gestures ☐ Sign Language

Augmentative Communication Device/Adaptive Device

☐Communication Board ☐Dynavox ☐Fingerspelling

Special Instructions _____
_____
_____

Hearing

☐ Normal ☐ Partially Impaired ☐ Total Loss

Adaptive Devices

☐ Hearing Aid (site: _____) ☐ Cochlear Implant (site:_____)

Special Instructions _____
_____
_____

Vision

☐ Normal ☐ Impaired ☐ Blind

☐ Right Eye ☐ Left Eye ☐ Both Eyes

Adaptive Devices

☐ Glasses ☐ Patch ☐ Contacts

Special Instructions _____
_____
_____

Mobility

☐ Walks ☐ Scooter ☐ Wheelchair ☐ Crutches ☐ Cane ☐ Walker ☐ Other: _____

Adaptive Devices

☐ Helmet ☐ Braces (site: _____) ☐ Prosthesis (site: _____)

Special Instructions _____
_____
_____

Transfers

☐ No Assist ☐ Standby ☐ Pivot ☐ Two-Person Assist ☐ Total Assist

☐ Weight Bearing ☐ Non-Weight Bearing

Adaptive Devices

☐ Lift ☐ Gait Belt ☐ Body Sling

Special Instructions _____

_____

_____

Feeding

☐ No Assist ☐ Partial Assist ☐ Total Assist

Diet

☐ Regular ☐ Soft ☐ Pureed ☐ Liquid ☐ Special Diet/Restrictions: _____

Adaptive Devices

☐ Gastrointestinal Tube ☐ Nasogastric Tube

☐ Formula Feedings(type: _____ amount: _____ times to be given: _____)

☐ Free Water (amount: _____ times to be given: _____)

Check Residuals

☐ No ☐ Yes

Feeding Pump

☐ No ☐ Yes (rate: _____)

Gravity Feed

☐ No ☐ Yes

Special Instructions _____

_____

_____

Hand and Face Washing

☐ Normal ☐ Partial Assist ☐ Total Assist

Special Instructions _____

_____

_____

Toileting

☐ Normal ☐ Incontinent (bowel, bladder, both) ☐ Needs Reminders ☐ Catheter

Surgical Diversion

☐ OstomyMitrafanoff ☐ Foley ☐ Toileting Aids

☐ Diapers/Briefs ☐ Urinal ☐ Catheter ☐ Tampons/Pads ☐ Wet Wipes

Schedule/Frequency/Special Instructions _____
_____
_____

Dressing

☐ Normal ☐ Partial Assist ☐ Total Assist

Types of Latches Needing Assist

☐ Buttons ☐ Zippers ☐ Snaps ☐ Velcro ☐ Shoe Laces

Special Instructions _____
_____
_____

Seizures

☐ No ☐ Yes

If yes, submit the Seizure Action Plan completed by health care provider.

Type of Seizure _____

Date of Last Seizure _____

Describe the seizure activity _____
_____
_____

Describe the postictal phase _____
_____
_____

Asthma/Reactive Airway Disease

☐ No ☐ Yes

If yes, submit the Asthma Action Plan completed by health care provider.

Oxygen Use

☐ No ☐ Yes (prescription from the health care provider must be on file)

Adaptive Devices

☐ Nasal Cannula ☐ Mask

☐ Flow Rate/Flow Range _____

Monitoring

☐ Pulse Oximeter (parameters _____ to _____)

In the past year has there been any history of behaviors that are inappropriate or destructive/dangerous to self, others, or property?

If yes, submit the Behavioral Modification Plan used at the school

Describe the behaviors _____
_____
_____
_____

Does your child have history of running away or wandering?

☐ No ☐ Yes

The Participant Health Profile is used to determine if the participant's needs (physically, developmentally, and emotionally) may be safely met by Discovery Club. The information provided is accurate and true to the best of my knowledge.

_____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Acute Illness Exclusion
Discovery Club wants to maintain a healthy environment for all its participants and staff and requests no child with acute illness attend Discovery Club.

_____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Exclusion Policy Based on Needs
If the child's needs exceed the service capacity of the program, the child may be excluded from the program.

_____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Sunscreen Permission Form

Date:_____

Name of Participant_____

Our staff members will assist with applying sunscreen to bare skin surfaces including the face, tops of ears, bare shoulders, arms, legs and feet 15-30 minutes before outdoor activities.
Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

Special Instructions:

___ My child may use the sunscreen provided by Easter Seals programs (Children's Sunscreen will be: broad spectrum, SPF 50 lotion, water resistant to at least 80 minutes, hypoallergenic, PABA free, fragrance free and gluten free)

___ I will provide sunscreen for my child (Please label)

___ I do not want my child to use sunscreen

_____
Parent name completing form (please print)

_____
Parent signature/Date

This permission form expires one year after it is signed by the parent.

Easterseals Colorado Agreement, Consent and Release

With the understanding that Easterseals Colorado will make every reasonable effort to prevent accidents, injuries or other mishaps, I acknowledge the following:

- The undersigned agrees to indemnify and hold harmless Easterseals Colorado – Discovery Club for any and all claims, demands, costs, expenses, including reasonable attorney's fees that Easterseals Colorado may suffer as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the Easterseals Colorado from any act of negligence or fault on the part of Easterseals Colorado, its officers, agents or employees.
- The undersigned does consent that photographs, video or motion pictures may be taken of the named applicant during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, website, publicity releases and/or other media.
- The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Discovery Club Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.
- The undersigned does hereby agree to allow participation of applicant in all Discovery Club activities (except those restricted).
- The undersigned gives permission for the applicant to ride in vehicles operated or leased by Easterseals Colorado – Discovery Club.
- The undersigned recognizes the right of the Discovery Club Director, in his/her absolute discretion, to terminate a child's stay at any time due to disciplinary or medical actions which might jeopardize the child's or others' health and safety at Discovery Club. The undersigned further agrees to pick up the child immediately upon being notified of such termination. Full Discovery Club fees are nonrefundable in case of above mentioned situations.
- The undersigned agrees not to send the applicant to Discovery Club if he or she has been exposed to a contagious disease within three (3) weeks of the starting date of camp, and to notify Discovery Club if this situation arises.
- If someone other than the undersigned is to pick up the applicant at the end of the Discovery Club session, such person must present **written** authorization from the undersigned. I do hereby authorize to pick up child.

  _____

  (Name) *(Address)* *(City)* *(State)* *(Zip)*

- Please list anyone in particular you do **NOT** want to pick up your child._____

In witness whereof I have hereunto executed this **Agreement, Consent & Release** on this date:

NAME OF CHILD: _____

LEGAL GUARDIAN'S SIGNATURE:_____ **Date:** _____

LEGAL GUARDIAN'S PRINTED NAME:_____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

State and Federal laws requires us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on June 1, 2013, and will remain in effect until it is amended or replaced by Easterseals Colorado.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Peggy Brown at Easterseals Colorado, Discovery Club. Information on contacting us can be found at the end of this Notice.

Typical Uses and Disclosures of Health Information

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement and/or complete HIPAA training.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, students in the healthcare professionals field of study, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials.

Abuse or Neglect: We may disclose your health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

Your Privacy Rights as our Patient/Participant

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact Peggy Brown at Easterseals Colorado, Discovery Club for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. When we make routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; and therefore are not available. You have the right to a list of instances in which we, our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back to August 1, 2011. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact Peggy Brown at Easterseals Colorado, Discovery Club if you want to further restrict access to your health care information. This request must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to Peggy Brown at Easterseals Colorado, Discovery Club. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Privacy Complaint form from Peggy Brown at Easterseals Colorado, Discovery Club. We support your right to the privacy of your information and will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

How to Contact Us

Peggy Brown
Discovery Club
720.339.7202
pbrown@eastersealscolorado.org

Chris Tyler
Respite Coordinator, Easterseals Colorado
303.233.1666 x 345
ctyler@eastersealscolorado.org

Notice and Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____	_____
Print Participant Name	Personal Representative Name (if applicable)
_____	_____
Signature	Date

Family Demographics

The Discovery Club is funded by a variety of funders. Several require demographic information of those that are being supported. Information is always provided as a congregate, no individual information is disclosed. Thank you for providing the following information.

Family Caregiver #1

☐ Male ☐ Female

Ethnicity

☐ Asian ☐ Black ☐ Hispanic (any) ☐ Multi Racial ☐ White

Family Caregiver #2

☐ Male ☐ Female

Ethnicity

☐ Asian ☐ Black ☐ Hispanic (any) ☐ Multi Racial ☐ White

# of children living in your household who have a disability _____

# of children living in your household who do not have a disability _____

Any other family members living in your household? _____

What is your annual household income?

☐ Less than $10,000
☐ $10,000 - $14,999
☐ $15,000 - $24,999
☐ $25,000 - $34,999
☐ $35,000 - $49,999
☐ $50,000 - $74,999
☐ $75,000 - $99,000
☐ $100,000 - $149,000
☐ $150,000 and above

MEDIA RELEASE

I grant to Easterseals Colorado and its affiliates, its representatives and employees the right to record and publish to the public my or my child's participation and appearance on video tape, audio tape, film, photography, social media, newsletters, broadcasts, brochures, publications, reports, web pages, promotional materials or any other audio-visual, electronic, printed, tangible work in any media or format, now known or hereafter to become known concerning my or my child's participation in Easterseals Colorado or its affiliates. I authorize the use of my or my child's name, likeness, voice, artwork and biographical material in connection with these recordings. I grant all rights to exhibit, publish or distribute these sound, still or moving images in whole or in part in any medium without restrictions or limitations for educational, promotional or any other purposes that support the mission of Easterseals Colorado or its affiliates.

I hereby release and hold harmless Easterseals Colorado and its affiliates, along with their respective employees, agents, sponsors, or other representatives from any and all claims, demands, or causes of action arising out of the use of my or my child's name and/or likeness, in accordance with the terms of this release. I understand and agree that neither I, nor my child, will be compensated in any way for the use of my or my child's name and likeness by Easterseals Colorado or its affiliates. I release and waive any claims or rights of compensation or ownership regarding such uses and understand that all such uses shall remain the property of Easterseals Colorado or its affiliates.

Publication and use shall not exceed three (3) years from the date of this release.

_____ _____
Signature of Participant Date

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Staff Signature Date