# Day Camp Application Packet

*Yay! Camp 2025*

Dear Family and Camper,

We would like to welcome you to Easterseals Colorado Day Camp! We are looking forward to a fantastic summer!

The enclosed forms *must* be completed and returned by mail *prior* to your child attending either day camp. This packet is required of all participants at this time. If you require additional copies, visit our website at www.eastersealscolorado.org.

In addition to the forms, the **non-refundable annual registration fee of $60/child must be submitted with your application**. Please write checks payable to Easterseals Colorado.

**Day Camp fees for the 2025 summer:** Yay! Camp is $100 per day for campers that require 1:1 staff ratio. $95 per day for campers that require a 2:1 ratio or higher. Camperships may be available. ****See Page 19****

Summer 2025 Yay! Camp will run Mondays through Thursdays from 8:30 a.m. to 4:00 p.m. from **June 9 to July 17, 2025** (Closed June 19 and July 4, 2025) at **Connections Church**, 2121 Dad Clark Dr. Highlands Ranch, CO 80126. Day Camps will provide snacks for each child. You will be required to provide a lunch. Extended hours must be arranged prior to day of camp and will have additional fees depending on time needs.

**Available dates are listed on Page 20 of this Packet.** Please mark the dates you are planning on attending.

**The application deadline is May 1, 2025.** Please use the following checklist to verify all information has been submitted by the application deadline.

- ☐ Day Camp Application *[Pages 2-13]*
  - ☐ **$60 Non-Refundable Registration Fee for 2025 [Page 2]*
  - ☐ **Copy of Medicaid/Medicare/Insurance Card [Page 3]*
  - ☐ **Recent Photo of Camper [Page 3]*
- ☐ Emergency Information *[Pages 4-5]*
- ☐ Health Profile *[Pages 6-11]*
- ☐ Medications *[Pages 12-13]*
- ☐ Sunscreen Permission *[Page 14]*
- ☐ Notice of Privacy Practices *[15-17]*
- ☐ Agreement, Consent and Release *[Pages 18-19]*
- ☐ Days Attending *[Page 20]*
- ☐ Demographics Information *[Page 21]*
- ☐ Authorization for the Administration of Medication *[Pages 22]*

**One Form for Each Medication to be Given at Day Camp is Required.*
*Each Child Must Have One Form for Sunscreen [Unless a Sunscreen Allergy or Adverse Reaction is Listed on Page 8]. Without Sunscreen, a Child Will Not be Allowed to Play Outside.*

If you have questions, please feel free to contact us by phone or email. We would be happy to answer any question you may have regarding Day Camps.

See you soon!

Krasimir Koev
*Chief Operating Officer*
303.233.1666 x 407
kkoev@eastersealscolorado.org

Peggy Brown
*Day Camp Coordinator*
720.339.7202
pbrown@eastersealscolorado.org

## DAY CAMP APPLICATION

**Participant Information**

Participant Name: _____ County of Residence: _____

Nickname: _____ Date of Birth: _____ Gender: _____ Ethnicity: _____

Primary Diagnosis: _____

_____

_____

Secondary Diagnosis: _____

_____

_____

**Funding Policy**

_____ I have read and understand the Funding Policy.
*Initial*

Type of Funding *(Check One)*:

☐ Self Pay ☐ CES Waiver ☐ CHRP Waiver ☐ FSSP

☐ Scholarship (Please email us if you are want to request a scholarship.)

The Camper's Fees will be Paid by *(Check One. If 'Other', Fill in the Blank)*:

☐ Parents/Gaurdian ☐ Agency ☐ Other: _____

*Payment is due by the week prior to the week of attendance.*

The Camper's Bill should be Sent to:

Contact Person/Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Additional information: _____

_____

**No refunds will be made if a Camper leaves Day Camp because of behavior problems or is sent home by the Camp Director.**

*(continued)*

## DAY CAMP APPLICATION *(Continued)*

**Funding Policy** *(Continued)*

To Pay by Credit Card, Circle One: VISA MASTERCARD

Cardholder's Name (PRINT): _____

Account Number: _____

Expiration Date: _____ CCV: _____

Cardholder's Signature: _____

Amount to be Charged: _____ Billing Zip Code for Card: _____

☐ 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/camper.

**Parent/Legal Guardian #1**

Name: _____
*First* *Last*

Physical Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Email: _____

*(continued)*

## DAY CAMP APPLICATION *(Continued)*

**Parent/Legal Guardian #2**

Name: _____
*First* *Last*

Physical Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Email: _____

**Is anyone not allowed to pick up the participant/camper from Day Camp?**

☐ Yes ☐ No

If Yes, please specify: _____

_____

## EMERGENCY INFORMATION

Name: _____ Date of Birth: _____ Program/Site: _____

Address: _____ Phone Number: _____

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 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 participant/camper. Only those people listed below, in addition to the parents/legal guardians, may pick up the participant/camper.

*(Continued)*

**DAY CAMP APPLICATION** *(Continued)*

Emergency Contact #1

Name: _____ Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact #2

Name: _____ Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

**Medical Contact Information**

Doctor Name: _____ Phone Number: _____

Address: _____

Dentist Name: _____ Phone Number: _____

Address: _____

Preferred Hospital 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. I also give permission for Easterseals Colorado to seek medical assistance in the event of a medical emergency for my child.

_____ _____

*Signature of Parent/Guardian* *Date*

*(continued)*

## DAY CAMP APPLICATION *(Continued)*

**Pick-Up Policy/ Late Pick-Up Policy / Sick or Behavioral Pick-Up Policy**

I understand the participant will only be released to a Parent, Legal Guardian, or Emergency Contact. An Emergency Contact must have valid picture identification for the participant to be released. Participants are to be picked up no later than 4:00 p.m. (unless otherwise arranged). The participant may not return to the program if two or more late pick-ups occur. 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*

## 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: _____

*(continued)*

## PARTICIPANT HEALTH PROFILE

Medication Allergies: _____

What Happens: _____

Treatment Required: _____

Are any of the Allergies severe requiring rescue medication? ☐ Yes ☐ No

**Communications/Speech**

☐ Verbal ☐ Non-Verbal ☐ Gestures ☐ Sign Language

Augmentative Communication Device/Adaptive Device

☐ Communications 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: _____

_____

*(continued)*

## PARTICIPANT HEALTH PROFILE *(Continued)*

**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:
☐ Yes ☐ No

Feeding Pump:
☐ Yes (Rate: _____) ☐ No

Gravity Feed:
☐ Yes ☐ No

Special Instructions: _____

_____

**Hand and Face Washing**

☐ Normal ☐ Partial Assist ☐ Total Assist

Special Instructions: _____

_____

**Dressing**

☐ Normal ☐ Partial Assist ☐ Total Assist

Types of Latches Needing Assist
☐ Buttons ☐ Zippers ☐ Snaps ☐ Velcro ☐ Shoe Laces

Special Instructions: _____

_____

*(continued)*

## PARTICIPANT HEALTH PROFILE *(Continued)*

**Toileting**

☐ Normal ☐ Incontinent (Bowel, Bladder, Both) ☐ Needs Reminders ☐ Catheter

Surgical Diversion

☐ Ostomy ☐ Mitrofanoff

Toileting Aids

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

Schedule/Frequency/Special Instructions: _____

_____

**Seizures**

☐ Yes ☐ No

☐ Type of Seizure _____

Date of Last Seizure: _____

Describe the Seizure Activity: _____

_____

_____

Describe the Postictal Phase: _____

_____

_____

**Asthma/Reactive Airway Disease**

☐ Yes ☐ No

*(continued)*

## PARTICIPANT HEALTH PROFILE *(Continued)*

**Oxygen Use**

☐ Yes ☐ No

☐ If 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?**

☐ Yes ☐ No

☐ If Yes, submit the Behavioral Modification Plan from School *[Pages 31-32]*.

Describe the Behaviors: _____

_____

_____

_____

**Does your child have a history of running away or wandering?**

☐ Yes ☐ No

*(continued)*

**PARTICIPANT HEALTH PROFILE** *(Continued)*

****All Campers Must Submit a Current Immunization Record prior to Attending Camp.****

The Participant Health Profile is used to determine if the participant's needs (physically, developmentally, and emotionally) may be safely met by Easterseals Colorado's day programs. 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**
Easterseals Colorado wants to maintain a healthy environment for all participants and staff, and requests no child with acute illness attend any program.

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

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

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

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

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

*(continued)*

## 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 Easterseals Colorado day camp) including creams, sunscreens, acetaminophen, and ibuprofen.

Medication #1: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #2: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #3: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #4: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

*(continued*

## MEDICATIONS *(continued)*

Medication #5: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

**Medication Policy**

Day Program staff may only administer medications under the direction of the participant's physician. All medications must be given to the Discovery Club Nurse/ Day Camp Directors 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 Day Programs 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 one year, 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 the last program day attended.

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

_____ _____
*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.

*(continued)*

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/PARTICIPANT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your/ participant protected health information, to notify you of our legal duties and privacy practices with respect to your/ participant health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your/ participant rights concerning your/ participant information. Our duties and your/ participant rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

**1. Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your/participant health information for certain purposes without your written authorization, including the following:

***Treatment.*** We may use or disclose your/ participant information for purposes of treating you/ participant. For example, we may disclose your/ participant information to another health care provider so they may treat you/ participant; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

***Payment.*** We may use or disclose your/ participant information to obtain payment for services provided to your/ participant. For example, we may disclose information to your/ participant health insurance company or other payer to obtain pre-authorization or payment for treatment.

***Healthcare Operations.*** We may use or disclose your/ participant information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

***Other Uses or Disclosures.*** We may also use or disclose your/ participant information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, to report deaths or certain crimes.

## NOTICE OF PRIVACY PRACTICES *(Continued)*

**2. Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your/ participant information as described below.

- To a member of your family, relative, friend, or other person who is involved in your/ participant healthcare or payment for your/ participant healthcare. We will limit the disclosure to the information relevant to that person's involvement in your/ participant healthcare or payment.
- To maintain our facility directory. If a person asks for you/ participant by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.
- To contact you/ participant to raise funds for Easterseals Colorado. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

**3. Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

**4. Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your/ participant health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your/participant care or payment for your/ participant care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you/ participant or others.
- You may request that your/ participant protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your/ participant protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

**NOTICE OF PRIVACY PRACTICES** *(Continued)*

**5. Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

**6. Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your/ participant privacy rights have been violated. You may file a complaint with us by notifying Melissa Angel. All complaints must be in writing. We will not retaliate against you/ participant for filing a complaint.

**7. Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Melissa Angel
*Vice President of Human Resources*
303.233.1666 x 410
393 S Harlan St, Suite 250
Lakewood, CO 80226
mangel@eastersealscolorado.org

**8. Effective Date.** This Notice is effective March 1, 2025.

_____
Name

_____ _____
Signature Date

_____
Parent/Guardian Name

_____ _____
Signature Date

## 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:

_____ *(initial)* The undersigned agrees to indemnify and hold harmless Easterseals Colorado – Day Camps 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.

_____ *(initial)* 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, web site, publicity releases and/or other media.

_____ *(initial)* 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 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)* The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted).

_____ *(initial)* The undersigned gives permission for the applicant to ride in vehicles operated or leased by the Easterseals Colorado.

_____ *(initial)* The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health and safety at camp. The undersigned further agrees to pick up the camper immediately upon being notified of such termination. Full camp fees are nonrefundable in case of above mentioned situations.

_____ *(initial)* The undersigned agrees to pay the full camp fee if the camper cancels one week or less prior to the check in day. This includes not arriving on check in day.

_____ *(initial)* The undersigned agrees not to send the applicant to Easterseals programs if he or she has been exposed to a contagious disease within three (3) weeks of the starting date of camp, and to notify Camp Director if this situation arises.

*(continued)*

**AGREEMENT, CONSENT AND RELEASE** *(Continued)*

_____ *(initial)* Weapons, pets, drugs and alcohol are not allowed at Summer Day Camp. An exception may be made for trained guide dogs for campers who require their services. The dog's owner assumes all responsibility for the care and actions of the dog. The dog must be free of disease and have a current rabies license or tag. Dogs that exhibit any behaviors that put Easter Seals' staff, campers or visitors at risk will not be permitted to remain. Costs to have the animal removed from the camp will be at the owner's expense. A copy of the dog's vaccines is required.

_____ *(initial)* If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned. I do hereby authorize to pick up camper.

_____
Name

_____ _____ _____
Address City State

_____ *(initial)* Please list anyone in particular you do NOT want to pick up your child or adult:

_____

_____

In witness where of I have here unto executed this Agreement, Consent And Release on this date:

_____
Legal Guardian's Printed Name

_____ _____
Legal Guardian's Signature Date

## YAY! CAMP ATTACHMENT

**LOCATION:** Connections Church, 2121 Dad Clark Dr.Highlands Ranch, CO 80126

**Please check the following dates the camper will be attending Yay! Camp:**

| Monday | Tuesday | Wednesday | Thursday |
|---|---|---|---|
| ☐ June 9 | ☐ June 10 | ☐ June 11 | ☐ June 12 |
| ☐ June 16 | ☐ June 17 | ☐ June 18 | CLOSED JUNE 19 |
| ☐ June 23 | ☐ June 24 | ☐ June 25 | ☐ June 26 |
| ☐ June 30 | ☐ July 1 | ☐ July 2 | ☐ July 3 |
| ☐ July 7 | ☐ July 8 | ☐ July 9 | ☐ July 10 |
| ☐ July 14 | ☐ July 15 | ☐ July 16 | ☐ July 17 |

**FINANCIAL REMINDER:**

**There is a non-refundable annual registration fee of $60 per camper. Daily camp fee cost is $100 per day for campers that require a 1:1 ratio and $95 per day for campers that require a 2:1 ratio or higher.**

**(The annual registration fee is due with the application, which must be submitted by May 1, 2025. The payment for daily camp fees are due by the week prior to the attending week.)**

**Per the signed Agreement, Consent and Release Form, a full daily fee will be due if the camper cancels one week or less prior to check-in day. This includes not showing up on check-in day. If camper's funding source is through a Community Center Board (CCB), the daily fee will be due and covered by the camper's family. We advise all families to take a *"realistic approach"* when marking days that the camper will attend. Unless you are absolutely certain that your camper can attend every single day of Yay! Camp's 2025 schedule, please do not mark all dates. You can always request additional days after submitting your application, and if there is availability, we will approve such requests.**

**Developmental Pathways is generously providing multiple scholarships to residents of Arapahoe, Douglas, and Elbert counties to attend Yay! Camp at any location.**

**For more information to see if you qualify contact: Peggy Brown at pbrown@eastersealscolorado.org.**

## DEMOGRAPHICS INFORMATION

This information will be compiled and used for reports to Easterseals National, foundations, and for grant applications. Actual camp costs are $125/day per camper. To keep costs for each camper at the current rate, this information is needed to receive donations, contributions, and for grant purposes.

**This information is in regards to the camper:** (Please check the correct information).

**Education:**

- ☐ Less than 12 years
- ☐ High School Graduate or GED
- ☐ Some College or Associate Degree

**Ethnicity:**

- ☐ Asian American
- ☐ African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Multiple Ethnicities

**Household Income:**

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 and above

**Household Count** *(If the camper is in a group home or host home, only the camper's information is required. If the camper is still living at home, total household count and income is required)*:

_____

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT EASTERSEALS COLORADO'S DAY CAMPS

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 Easterseals Colorado Day Programs, 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 ☐ Yes (Specify: _____)

ALLERGIES: ☐ No ☐ Yes (Specify: _____)

Medication shall be administered from: _____ to _____
*Month / Day / Year* *Month / Day / Year*

Prescriber's Name/Title: _____

_____

Telephone: _____

Address: _____

_____

*Use for Prescriber's Stamp*

_____ _____
*Prescriber's Signature* *Date*