Easterseals Camp Challenge
2019 Overnight Summer Camp Application

We are delighted to give you the Easterseals Camp Challenge 2019 summer camp application. We want to thank you for your interest in attending our camp this year and have many exciting programs and activities planned for your enjoyment. **Please be sure to read and complete the application carefully as there have been changes to best meet the needs of campers and families. ALL CAMPERS ATTENDING CAMP CHALLENGE IN 2019 MUST COMPLETE THIS APPLICATION – Please do NOT use previous applications.**

Once you have completed in full all the enclosed forms, please send them to:
Easterseals Camp Challenge, 31600 Camp Challenge Road, Sorrento, FL 32776.

Please be sure to have the following items completed and enclosed in your application packet:

- ☐ Completed Application form with legal guardian signature(s) and all pages initialed (pages 1-6)
- ☐ Medical and Liability release/Insurance information form/HIPPA (page 7)
- ☐ Fee and Payment Information with Signatures (page 8)
- ☐ T-Shirt order form – payment must be included with deposit (page 9)
- ☐ Financial Assistance form (must be completed if requesting financial aid or using CDC+) (page 10 & 11)
- ☐ Text Message Authorization (page 12)
- ☐ Media Release (pages 13 & 14)
- ☐ Payment for deposit or full amount.
- ☐ Current photograph of camper
- ☐ Current copy of insurance card

PAGES 1-13 PLUS PAYMENT, INSURANCE CARD, AND PHOTO ARE CONSIDERED THE FULL APPLICATION AND MUST BE SUBMITTED TOGETHER

- ☐ Medical Information and physical form (completed by physician) (pages 15 & 16)

MEDICAL FORM MUST BE COMPLETED WITHIN 45 DAYS OF CAMPER ARRIVING AT CAMP – DO NOT SEND NOW

NOTE: Pages 17 & 18 are Easterseals Florida's Notice of Privacy Practices – Do not return these 2 pages - keep them for your records.

Once accepted to the summer camp program, a confirmation letter and further information will be sent to you regarding preparations for camp. These letters are usually sent in April once financial aid has been awarded. NEW this year – acceptance letters will be sent via email. We ask that you provide as much detail as possible so that we can best meet the needs of the camper and provide the most enjoyable experience possible. **Medication will need to be placed into daily pill boxes – the original bottles will also need to be brought with you to camp – signed medical form must be completed no earlier than 45 days prior to arriving at camp.**

Please note: We cannot fully process an application and confirm acceptance to the program without a deposit and a completed application packet. Incomplete applications will be returned and acceptance into the program will not be guaranteed. DO NOT SEND THE SIGNED MEDICAL FORM WITH THE APPLICATION UNLESS YOU APPLY WITHIN 45 DAYS OF ATTENDING CAMP.

Regardless of session, all payments for Summer Camp must be **paid in full** by:

- ***February 15th*** to be eligible for Early Bird discount,
- and by ***May 15th*** for all other payments.

Failure to pay in full will forfeit that camper's spot at Camp.

Please direct any questions to:
Email: camp@fl.easterseals.com or Phone: (352) 383 - 4711

Easterseals Camp Challenge

Overnight Summer Camp Application

Summer Camp Dates	
☐	**Session 1 – June 9-15, 2019 ADULTS** (18 and up)
☐	**Session 2 – June 16-22, 2019 ADULTS** (18 and up)
☐	**Session 3 – June 23-29, 2019 ADULTS** (18 and up)
MID-SUMMER BREAK NIGHT – THERE WILL BE NO CARRY-OVER BETWEEN SESSION 3 AND 4 - ALL CAMPERS CHECK-OUT	
☐	**Session 4 – June 30 – July 6, 2019 ADULTS** (18 and up)
☐	**Session 5 – July 7-13, 2019 YOUNG ADULTS** (16-24 years)
☐	**Session 6 – July 14-20, 2019 KIDS** (Under 18 years)

****Session Ages are a guideline - If you have questions about the age range for a session or the appropriate session for a camper please contact the camp office****

General Information

Camper's Full Name:_____

Address: _____ - _____
Street *City* *State* *Zip* *County*

DOB: ____/____/____ Age: _____ Sex:_____ Height: _____ Weight: _____ Ethnicity: _____

Phone: (_____)_____ Email: _____

Caregiver Email if Different:_____

Veteran Status: Active Duty ☐ Veteran ☐ Family Member of a Veteran ☐ None ☐

Is this your first time attending Camp Challenge? ☐ Yes ☐ No

If so, how did you hear about Camp Challenge? _____

	PAYER Party responsible for camper PAYMENT	**EMERGENCY CONTACT during camp session:** ☐ Same as Payer
Name		
Address		
Phone		
Relationship to Camper		

	LEGAL GUARDIAN Camper his/her own Legal Guardian? ☐ Yes ☐ No If no, please complete: ☐ Same as Payer	**WHO THE CAMPER LIVES WITH?** ☐ Caregiver ☐ Group Home ☐ Foster Home ☐ Same as Payer
Name		
Address		
Phone		
Email		

Name of Individual(s) That Camper May Be Released To: _____

Disability & Behavioral Information

Can the camper maintain their behavior and have their needs met in a 3 : 1 camper : staff ratio? ☐ **Yes** ☐ **No**

Disability (please check all that apply):

☐ Down's Syndrome	☐ Cerebral Palsy	☐ Spina Bifida	☐ Autism
☐ Metabolic Disorder	☐ Asperger's Syndrome	☐ ADHD/ADD	☐ Seizure Disorder
☐ Muscular Dystrophy	☐ Prader Willi Syndrome	☐ Visually Impaired	☐ Hearing Impaired
☐ Intellectual Disability	☐ Other (Please List)		

For New and Returning Campers: Please answer all questions below.
ALL Campers MUST complete the entire application – please use as much detail as possible so we can best assist campers while they are at camp – we use all the information you provide!

***Behavioral*:** Please help us in making this camp experience enjoyable by indicating which of the following behaviors may pertain to the camper:

☐ Self-Injury	☐ Spitting	☐ Biting	☐ Property Destruction
Elopement:	☐ Physical Aggression	☐ Inappropriate Language	☐ Not Following Directions
☐ Running Far Away	(kicking/hitting/punching)	☐ Sexual Acting Out	☐ Yelling
☐ Leaving the Area			
☐ Other			

Please describe in detail when these behaviors typically occur, what they look like, how long they last, and what you typically do to calm the situation:

_____
_____
_____
_____

What additional information pertaining to disability, severity or behavioral challenges should camp staff be aware of?

_____
_____
_____
_____

Functioning and Communication

Communication & Social Skills:

Can camper communicate wants and needs effectively to others? ☐ Yes ☐ No

How does camper communicate? (Please check all that apply):

☐ Verbally	☐ Sign Language	☐ Electronic Device	☐ Gestures
☐ Other			

How does camper adjust to new situations/new people?

_____
_____

Does camper have any routines that are significant for camp staff to be aware of? If yes, please explain: ☐ Yes ☐ No

_____
_____

Is this the campers first time being away from home? ☐ Yes ☐ No

Are transitions (moving from one activity/place to another) a challenge for camper? ☐ Yes ☐ No

If yes, please explain and include details on strategies that are successful:

_____
_____

Transferring:

Does camper need assistance with transfers? ☐ Yes ☐ No

Please check if camper requires any of the following transferring techniques:

☐ 2-person Lift	☐ Hoyer Lift	☐ Stand Pivot

Eating:

Does camper require special feeding (i.e. G-tube) ☐ Yes ☐ No

Please Explain _____

Can camper feed themselves? ☐ Yes ☐ No

Does camper require assistance eating (i.e. using special utensils, dicing or pureeing food, etc)? ☐ Yes ☐ No

Please Explain _____

Camper's appetite is: ☐ Good ☐ Average ☐ Poor

How many glasses of water does the camper typically drink per day?

Special dietary needs are (Please be specific):

_____

_____

_____

Food Allergies/Restrictions:

_____

Toileting:

Does camper utilize any of the following equipment? (Please check all that apply) ☐ Yes ☐ No

☐ Shower Chair ☐ Indwelling Catheter ☐ Intermittent Catheter

Does camper have bladder control? ☐ Yes ☐ No

Does camper have bowel control? ☐ Yes ☐ No

Does camper suffer from constipation? If so, please describe preventative or methods for relieving: ☐ Yes ☐ No

_____

Does camper need reminders/prompting? ☐ Yes ☐ No

Does camper use diapers? ☐ Yes ☐ No

Does camper need assistance during toileting? If so, please explain type of assistance needed: ☐ Yes ☐ No

_____

Hygiene:

Wash and Dry Hands	☐ Independent	☐ Needs Help Explain:_____
Brush Teeth	☐ Independent	☐ Needs Help Explain:_____
Dressing	☐ Independent	☐ Needs Help Explain:_____
Shower/Wash hair	☐ Independent	☐ Needs Help Explain:_____
Shaving	☐ Independent	☐ Needs Help Explain:_____
Menstruation	☐ Independent	☐ Needs Help Explain:_____

Sleeping:

Does camper sleep through the night (6-8 hours)? ☐ Yes ☐ No

Does camper require turning throughout the night? ☐ Yes ☐ No

If Yes, How often? _____

Does camper require bed rails? ☐ Yes ☐ No

Does camper wet bed? ☐ Yes ☐ No

Fears:

☐ Dark ☐ Insects ☐ Noises ☐ New Surroundings

☐ Crowds ☐ Clowns ☐ Animals ☐ Heights

☐ Other _____

Is there any information regarding things camper does not like that would be helpful for camp staff to know (e.g. physical touch, activities, foods) ☐ Yes ☐ No

If yes, please explain:

_____

_____

Special Equipment & Mobility

Camper is: ☐ Ambulatory/Can walk independently ☐ Semi-Ambulatory/Can walk with assistance from staff or from assistive device ☐ Non-Ambulatory

Adaptive Equipment: **Please check all special equipment that the camper will use and will be brought to camp:**

☐ Glasses ☐ Hearing Aids ☐ Dental Retainers/Devices ☐ Adaptive Utensils
☐ Walker/Cane ☐ Crutches ☐ Orthotic Leg Braces ☐ Prosthesis
☐ Wheelchair (☐ Electric / ☐ Manual/ ☐ Stroller) ☐ Other _____

Special Instruction: _____

_____

Please describe camper's ability to operate wheelchair (if applicable):_____

_____

Please include details regarding independence to be able to use chair and controls:_____

_____

Recreation & Activities – All campers MUST complete this section – Initial EACH Section

Please list the activities (sports, hobbies, etc) the camper currently participates in:

_____

Does the camper have any adaptive equipment to assist with participation in activities? If yes, please explain: ☐ Yes ☐ No

_____

Does the camper have any limitations to being outside in the sun/heat for approximately 45 minutes at a time? ☐ Yes ☐ No
If yes, please explain:

_____

Swimming: Please check all that apply regarding camper's swimming ability. Camper may participate _____ (initial)

☐ Swims well without assistance ☐ Swims with assistance ☐ Non-swimmer
☐ Other information pertaining to swimming/pool:

_____

Nature/Farm: Camper may participate _____ (initial)

Does the camper have any allergies to animals? If yes, please explain: ☐ Yes ☐ No

_____

Does the camper have any fear of animals? If yes, please explain: ☐ Yes ☐ No

_____

Sports & Games (including target range): Camper may participate _____ (initial)

What sports has the camper participated in previously?

_____

Does the camper participate well in group activities? If no, please explain: ☐ Yes ☐ No

_____

Challenge/Ropes Course: Camper may participate _____ (initial)

Has the camper ever done a challenge course/zip line before? ☐ Yes ☐ No

Is the camper afraid of heights? ☐ Yes ☐ No

Arts & Crafts:

What types of crafts or art (drawing, painting, making beaded necklaces, etc.) does the camper enjoy?

_____

Are there any behaviors or limitation that would prevent the camper from participating in arts & crafts? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Please list any additional likes or dislikes pertaining to the recreation of the camper:

_____

Medical Data (this section does NOT need to be completed by physician)

This section MUST be completed each year even if the camper attended previous summers.

General Health: Does camper have any of the following:

☐ Asthma ☐ Seizures ☐ Frequent Ear infections ☐ Diabetes
☐ Heart Problems ☐ Bleeding/Clotting disorders ☐ ADHD ☐ Circulatory problems
☐ Other: _____

List Any Recent Operations, Serious Injuries or Recurring Illnesses: _____

Has Camper Been Hospitalized Within the Last 12 Months? ☐ Yes ☐ No

If Yes, Please Explain: _____

Has Camper Been Treated In An Emergency Room Within The Last 12 Months? ☐ Yes ☐ No

If Yes, Please Explain: _____

Allergies:

☐ Food: _____ ☐ Insects: _____
☐ Plants: _____ ☐ Medicines: _____
☐ Other _____

Seizures: Does camper have seizures/seizure disorder? ☐ Yes ☐ No

For campers with a history of seizures, a Seizure Plan will be sent with the Acceptance Packet that must be retuned prior to attendance.

Type of seizures

☐ Grand Mal
☐ Absence (loss of consciousness)
☐ Myoclonic/Clonic (jerking)
☐ Tonic (muscle stiffness/rigidity)
☐ Atonic [loss of muscle tone]

Frequency of seizures: _____
Duration of seizures: _____
Date of last seizure: _____
Are seizures controlled with medication? ☐ Yes ☐ No
When to Notify Emergency Contact? ☐ Every Time ☐ Over 5 Minutes ☐ Other_____

Please describe what camper's seizure looks like (include behavior before, during and after event):

_____
_____

Medications:

NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order. Please make sure the medication list is complete on the Medical Information Form.

Instructions on packaging medication for camp will be sent with the acceptance packet – medication is ONLY dispensed at camp the way it is written on the prescription bottle.

Are there any special techniques used or information that may be helpful to camp staff regarding administering of medications to camper? If yes, please explain: ☐ Yes ☐ No

_____
_____

Any change in campers medications in the last 90 Days? If Yes, Please explain: ☐ Yes ☐ No

_____
_____

Please Describe Any Additional Medical Concerns:

_____
_____

Camper's Name: _____

Physician's Name: _____ Phone # ( ) _____

Application Completed By: _____ _____ Date: _____
Print *Signature*

Relationship to Camper: _____ Phone #: ( ) _____

Medical and Liability Release/Insurance Information

THIS FORM **MUST** BE COMPLETED AND SIGNED BY THE **LEGALLY RESPONSIBLE CAMPER OR GUARDIAN**.

Easterseals Florida - Camp Challenge carries a limited Camper's Accident and Sickness Insurance Policy covering all campers. Details of this may be obtained by contacting the camp office. Pre-existing conditions are not covered under this policy. All medical expenses not covered under Camp Challenge's Accident and Sickness Policy will be the responsibility of the legal guardian. The following information is required for camp records. Please complete with respect to the hospitalization and/or major medical insurance covering the camper.

Name of Insurance Carrier: _____
Policy Holder: _____
SSN#:_____

Policy Number: _____
Certificate Number: _____
Code or Group Number: _____
Medicare/Medicaid Number:_____

I hereby give permission for _____(camper name) to receive any examinations and any medical or surgical treatment which the camp's nurse, camp's physician, or any other referred physician, dentist or hospital may determine to be advisable during the camper's period of attendance at Camp Challenge.

This health history is current to the best of my knowledge and belief; and the camper herein described has permission to engage in all prescribed activities, except as noted. Reports and records may be requested from or sent to doctors and referring agencies. This form may be photocopied for use outside of Camp.

I am in receipt of the Easterseals Florida's Notice of Privacy Practices. _____
(Please Initial Here)

I release and completely discharge Easterseals Florida, Inc., Camp Challenge, its officers and directors, and any persons in privity with any of them, from any and all liability, legal responsibility, claims, damages, or causes of action arising from any and all damage or injury to my person or property, including my death that may occur while on Easterseals property or being provided services by volunteers or contractors of Easter Seals, and hereby waive all such claims or causes of action. This release, discharge and waiver is intended to apply even to affirmative acts of negligence on the part of the released parties, i.e. Easterseals Florida, Inc. and/or its representatives, agents, employees, officers, directors, volunteers, consultants or contractors.

If I am injured, I agree not to sue Easterseals Florida, Inc., Camp Challenge, or any officers, directors, representatives or agents thereof, or start any other type of legal action as a result of any damage or injury I may incur. In the case of my death, I hereby direct my personal representatives, heirs, executors, next-of-kin, or spouse not to sue these parties on behalf of my survivors or my estate.

_____ _____
Signature of Legal Guardian *Date*

_____ _____
Witness *Date*

Please include:

1. **Copy of insurance card (front and back) or Medicare/ Medicaid card with this form**
2. **Please be sure to attach a current photograph of the attending camper to this application.**

Fee and Payment Information

Fee Worksheet

>>Must be completed and signed even if camper is applying for financial assistance<<

THIS FORM MUST BE COMPLETED FOR EACH CAMPER

Please complete the fee chart below to determine camper's final fee, even if you are applying for financial aid. Financial aid is limited, dependent on availability, and not guaranteed.

Camper Name: _____

Campers may attend more than one session within their designated age groups. Age groups are a guideline for providing an age appropriate experience. Speak to camp director for adjustments needed. Campers staying more than one consecutive session will be charged an addition $135 per session for each carryover weekend. This fee is an addition to other fees and is not part of the early bird discount.

EXAMPLE: A camper staying session 1 and 2 applying for the early bird discount would pay $1785. The regular registration would be $2085. This does not include any tee shirts. Add an extra $15.00 for each tee shirt.

List below the appropriate session fee(s) & carryover weekend fee(s) that camper will be attending.

1. Payment By Selection:
   a. $825 per session (early bird fee) if paid in full by February 15th
   b. $975 per session fee if paid after February 15th
2. Add in $135 carryover for each weekend between sessions you are staying.
3. Add in $15 for each tee shirt you order
4. Then total all lines at bottom:

Mark "✓" below to make your reservation								
Choose your Session Fee: **Regular Session Fee –** Full Payment after 2/15/19 **Early Bird Rate –** Full Payment by 2/15/19	**Regular Session Rate** ☐		**Early Bird Rate** ☐		**Carryover Weekend Fee (If Applicable)**			
☐ **Session 1 – June 9-15 2019** (18 and up)	**$975.00**	**or**	**$825.00**	**+**	**$135.00**	**=**	**$**	
☐ **Session 2 – June 16-22, 2019** (18 and up)	**$975.00**	**or**	**$825.00**	**+**	**$135.00**	**=**	**$**	
☐ **Session 3 – June 23-June 29, 2019** (18 and up)	**$975.00**	**or**	**$825.00**		**No Carry-Over**	**=**	**$**	
☐ **Session 4 – June 30- July 6, 2019** (18 and up))	**$975.00**	**or**	**$825.00**	**+**	**$135.00**	**=**	**$**	
☐ **Session 5 – July 7-13, 2019** (16-24 years)	**$975.00**	**or**	**$825.00**	**+**	**$135.00**	**=**	**$**	
☐ **Session 6 – July 14-20, 2019** (Under 18 years)	**$975.00**	**or**	**$825.00**		**No Carry-Over**	**=**	**$**	
					Total	**=**	**$**	
Amount of Enclosed Payment: A $300 deposit **per session** is required to hold each session. Deposits are non-refundable once camper is accepted into the camp program.							**$**	

Will you be applying for Financial Aid (not available for Early Bird Rate)? ☐ **Yes (Income documentation required)** ☐ **No**

Campers using CDC+ or APD Funds are NOT eligible for Early Bird pricing unless the fees are paid by February 15th

By signing below I acknowledge:

- All camp fees, including deposits, are non-refundable once camper is accepted into the camp program.
- That if camper submits an application along with payment and the camper is deemed ineligible to attend Camp by Easter Seals Florida management prior to session, the deposit check, and any other funds, will be returned in full.
- That if camper fails to complete their scheduled camp session(s) for any reason, or gets sent home from camp for any reason, no refund or credits will be given.
- That all camp fee payments will be forfeited for campers who fail to attend assigned session(s).
- Campers using CDC+ must add Easterseals Florida as payee to have funds sent directly to ESF. If ESF is not added as payee, all fees must be paid in advance by the appropriate deadlines.

_____ _____ _____

Signature of legal guardian *Printed name of legal guardian* *Date*

_____ _____ _____

Signature of payer (If different than person above) *Printed name of payer* *Date*

Easterseals Camp Challenge
2019 T-Shirt Order Form

Dear Camper,

As is the camp tradition, we are again having a T-Shirt made to commemorate the summer camp season. A place for your name to be written will be on the left sleeve with "2019" below. All T-Shirt orders include a white shirt to tie-dye at camp.

All T-Shirts must be pre-ordered. If you would like to order a T-Shirt, please fill in the form below and include it with your application.

Camper Name: _____

T-Shirt Sizes: (Please write number of each size you would like)

Child S **($15)** _____	Adult S **($15)** _____	Adult 2XL **($15)** _____
Child M **($15)** _____	Adult M **($15)** _____	Adult 3XL **($15)** _____
Child L **($15)** _____	Adult L **($15)** _____	Adult 4XL **($15)** _____
Child XL **($15)** _____	Adult XL **($15)** _____	Adult 5XL **($15)** _____

Include payment for camp deposit and t-shirt with your application.
Please add the appropriate amount based on the number of T-Shirts ordered and number of sessions.

Total Deposit and T-Shirt Amount: _____
(example: $300 deposit for one week session + 1 size T-Shirt = $315 total due)
T-Shirts will not be ordered until payment has been received.

Payment Options

☐ **By Check/Money Order**	☐ **By Credit Card:**
Make checks payable to Easter Seals Florida **Mail to:** Easter Seals Florida - Camp Challenge 31600 Camp Challenge Road Sorrento, FL 32776	☐ Visa ☐ MasterCard ☐ American Express Credit Card # _____ v-code# _____ Exp. Date _____/_____ Card Holder Name _____ Signature _____
☐ **Pay by phone:** Contact the Camp Office at 352.383.4711 Monday to Thursday between 9:00 am and 3:30 pm.	

If you have any questions or concerns, please do not hesitate to call.
Camp Director 352.383.4711

**A CDC+ Authorization must be provided.

**Easterseals Florida MUST be named the payee and the funds MUST be submitted directly to Easterseals. (Camp will provide the necessary paperwork).

**If for any reason Easterseals is not made a payee on the CDC+ account, payment must be received prior to attendance at camp.

**Any monies not paid by CDC+ will be the reasonability of the camper or legal guardian.

CDC+ Client Number: _____

Easterseals Florida
Financial Assistance Application
Required to receive Financial Assistance

Easterseals Florida's (ESF) work is driven by its purpose to make profound, positive differences in the lives of people with disabilities every day.

ESF makes financial assistance available, as finances permit, for its services to individuals with disabilities, for whom outside funding is unavailable and the services are beyond the scope of the individual/families financial means.

ESF believes that a strong sense of ownership, commitment and pride is developed if the financial assistance recipient has contributed to the cost of services, therefore, all financial assistance recipients will pay a portion of the cost of services. Volunteer hours may also be required by the program.

Assistance is granted strictly within the current fiscal year of ESF. Recipients may reapply within 30 days of the expiration of the current award.

How to Apply:

Applicants must complete all sections of the Financial Assistance Application. Please do not leave any spaces blank. Documentation from all sources of income must be provided.

Required documentation:

- A copy of your most recent IRS income tax return (if status is married filing separately, both forms are required)
- If you do not file a tax return, documentation of your income - for example: a copy of your SSI letter

You must apply (submit completed application and required documentation), with the Camp office receiving all information by **March 15th**. You will receive determination by March 31st. Any Financial Assistance applications and required documents received after March 15th will be considered based on availability of funds. Incomplete packets will not be considered.

All information contained in the Financial Assistance Application will remain confidential.

Financial Assistance Application

Program: **EASTERSEALS CAMP CHALLENGE – SUMMER OVERNIGHT CAMP**

Date: _____

Camper/Client: _____

Parent/Caregiver/Guardian: _____

Address_____

_____

Email: _____

Phone: _____ County of Residency _____

New Client: ❒ Existing Client: ❒

Client IRS Tax Status: ❒ Files own return ❒ Claimed as dependent by _____

Total # of Exemptions from last IRS 1040/1040EZ: _____

Total Adjusted Gross Income from last IRS 1040/1040EZ: $_____

Current monthly gross income: $_____

Here's why it changed: _____

_____

_____

Special Circumstances: _____

_____

Total number of household members: _____

Are there any other sources of household income? _____

VERIFICATION AND AUTHORIZATION

I declare that all of the information I have provided on this request for financial assistance is complete and accurate to the best of my knowledge. I understand incomplete applications (including those missing required documentation) will not be processed. In addition, I attest that I have sought all available third party funding available and agree to comply with the requirements of funders to obtain all third party funding, if qualified.

Signature of Client/Representative: _____ Date: _____

Office Use Only

Financial Assistance funding source: _____

Service:_____ Frequency: _____

Total amount approved: $_____ Start Date: _____ End Dates: _____

Approved by (Director): _____ Date: _____

Approved by Sr. VP (Over 25%) _____ Date: _____

Copy: Accounting Original: Program File Scan: Pro-Care Documents Note: Pro-Care Journal Copy: Staff member recording Charges/Pmts to ProCare April 11, 2009
Revised 9/27/16

Authorization to Receive Protected Health Information via Text Message

Client: _____

Last First DOB

Parent/Legal Guardian: _____

Last First Relationship to client

I give permission for Easterseals Florida to send/receive information via text message to my electronic device that may contain protected health information. Protected health information can include the client's name, date of birth, address, diagnosis, treatment plan, medications, photos and any other medical related information. By signing this authorization, I understand that the information will not be encrypted and will not be secure. I also understand that there may be some level of risk that information in an unencrypted text message could be read by someone other than myself. Any information disclosed in accordance with this authorization may be re-disclosed by a recipient and is no longer protected by federal or state health privacy laws.

I understand that this authorization is voluntary and that Easterseals Florida will not condition any treatment or funding to the client on the completion of this authorization. I understand I have the right to revoke this authorization at any time.

Revocation will be provided in writing to Easterseals Florida. Revocation will not apply to any information that has been released following receipt of this authorization and prior to revocation. This authorization is valid until the client is no longer receiving services with Easterseals Florida.

The telephone number(s) that I am authorizing to receive the text messages described above is:

Please initial below:

☐ I will inform Easterseals Florida of changes to my telephone number immediately. I understand that Easterseals Florida is not responsible for any communications sent to my former number, listed above, during the lapse in time from previous number to my new number.

Parent / Legal Guardian: Signature _____ Date: _____

Authorization – Use of Disclose Protected Health Information
Media and Testimonial Release

Date: _____

Name: _____ Birth Date: _____

_____
Street Address Apt #

_____
City State ZIP

We appreciate the fact that you would like to provide information, a testimonial or comment about your experience or care received from us. With your permission and authorization we may use your information in printed materials, on our web site, on social media we create (e.g. Twitter, Facebook, Instagram), and we may release it to the media. We may send text messages e.g. photos internally to other Easterseals Florida staff to obtain approval prior to use. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. We may respond to a comment you post on social media we maintain or thank you for your testimonial. If we respond or thank you we will not use or disclose any information you have not previously authorized. Any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of you made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and these materials may be released to the general public. You assign to Easter Seals Florida all of your rights to these materials. This form explains your authorization. Please use it to authorize Easterseals Florida to use or disclose your information. We will give you a copy.

Authorization

I authorize Easterseals Florida to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my experience or care I have received. This includes posting my comment on social media maintained by or for Easterseals Florida. My authorization to use my information extends to any persons working on behalf of Easterseals Florida to create or maintain materials in any format that may include my information, testimonial or comment including but not limited to printed materials, web sites and social media. I authorize Easterseals Florida to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Information to be used or disclosed may include the following:
   - client's photograph
   - client's name (whole or part)
   - client's story or testimonial
   - audio or video recording of client
   - comments written by client or guardian

   If there is something listed above that you do not want disclosed, please write it in the box below.

2. Identification of persons to whom use or disclosure of the information described in Section 1 may be made
   The information described above may be used or disclosed to the general public who may view or read the information on materials created by or for Easterseals Florida including but not limited to photographs, videos, printed materials, web sites and social media.

3. Purpose
   The purpose of this Authorization is to permit Easterseals Florida to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its web site, social media, social media web site, newsletters, printed materials and press releases. Easterseals Florida will not receive any payment or financial remuneration from anyone for use or disclosure of this information. The materials created by Easterseals Florida, its employees and agents are owned by Easterseals Florida. The materials do not need to be submitted to me for further approval.
4. Expiration Date of this Authorization
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand

1. I may revoke this authorization at any time by giving Easterseals Florida notice of my revocation in writing to Rikesha Blake, Corporate Compliance Officer, 2010 Crosby Way, Winter Park, FL 32792
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Easterseals Florida written notice of my revocation.
3. Easterseals Florida may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing Easterseals Florida to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

To be completed by Easterseals Florida staff:

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Easterseals Florida by:

_____

Signature Printed Name and Title

EASTERSEALS CAMP CHALLENGE
CAMPER MEDICAL INFORMATION

(Pages 15 & 16 only are to be completed and signed by a Licensed Physician – 2 pages)

MUST BE COMPLETED WITHIN 45 DAYS OF CAMPER ARRIVING AT CAMP.

NOTE TO PHYSICIAN: PAGES 15 AND 16 OF THE 15 PAGE APPLICATION DOCUMENT ARE THE CAMPER MEDICAL INFORMATION FORMS TO BE SIGNED BY YOU.

Camper Full Name:_____

Address: _____

DOB: **/ /** ***Age:*** _____ ***Sex:***_____ ***Phone:***

HEALTH EXAMINATION √ = satisfactory X = unsatisfactory (explain) 0 = Not Examined

Height:	**Weight:**

Eyes:	**Lungs:**	**Posture:**	**Sensation:**
Nose:	**Heart:**	**Balance:**	**Circulation:**
Ears:	**Abdomen:**	**Coordination:**	**Nutrition:**
Teeth:	**Skin:**	**Spasticity:**	**Hernia:**
Throat:	**Extremities:**	**Motion Limits:**	**Genitalia:**

Applicant's primary disability (Medical Diagnosis): _____

Secondary disability (if any): _____

Applicant is under the care of a physician for the following condition(s):_____

_____

Current Treatments: _____

Camp Challenge medical staff routinely administer the following over-the counter medications. Please check all medications that may be given to the camper on an as-needed basis.

☐ **Camper may have ALL of the below listed medications**

☐ Acetaminophen 325mg ☐ Ibuprofen ☐ Barrier Cream (Zinc Oxide) ☐ Eye Drops (Visine)
☐ Diphenhydramine HCL ☐ Glycerin Suppository ☐ Antacid (Tums) ☐ Pepto Bismal
☐ Hydrocortisone Cream ☐ Triple Antibiotic Cream ☐ Aloe ☐ Nasal Decongestant
☐ Cold and Allergy Medicine

CURRENT ADDITIONAL OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP:

(Please also include any supplements or vitamins the camper currently takes).

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

Date_____ Physician's Signature _____

MEDICAL FORM **PAGE 1**

Camper Name: _____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP:

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

*****NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order*****

ALLERGIES: (Food, drugs, plants, insects) _____

_____

SEIZURES: Yes _____ No _____ Type _____Date of last seizure: _____

Seizure Triggers: _____ Medication Controlled? (list) _____

Can the camper be outside for approximately 1 hour at a time? ☐ Yes ☐ No

Can the camper safely sleep overnight in a cabin environment? ☐ Yes ☐ No

Is the camper at excessive risk for dehydration? ☐ Yes ☐ No

Bowel Habits: Frequency? _____ Preventive medications (e.g.: Miralax)? _____

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

_____

_____

_____

PHYSICIANS STATEMENT:

I have examined the camp applicant. In my opinion, the camper is

Able [ ] NOT Able [ ] to participation in an active camp program.

_____ _____

Licensed Physician's Signature *Physician Name (printed)*

_____

Date of Most Recent Examination

Physician Address:_____

City_____ State _____ Zip Code _____

Phone: ( ) _____

MEDICAL FORM **PAGE 2**

CAMPER/LEGAL GUARDIAN COPY-DO NOT RETURN WITH PACKET

NOTICE OF PRIVACY PRACTICES (HIPPA)

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

This Notice is effective as of April 14, 2003.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in lobby, reception area and on our web site. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Rikesha Blake. You can contact the Privacy Officer at (407) 629-7881.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

Keep this page for your records – Do Not Return

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the *Secretary of the Department of Health and Human Services* ***about our privacy practices. You will not face retaliation from us for making complaints.***

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are <u>required</u> to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are <u>allowed</u> to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

We may contact you for fundraising efforts.