

Easterseals Camp Challenge 2021 Overnight Summer Camp Application

Hello Campers! We are so excited to be welcoming campers back to camp and provide the Easterseals Camp Challenge 2021 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 due to COVID-19. ALL CAMPERS ATTENDING CAMP CHALLENGE IN 2021 MUST COMPLETE THIS APPLICATION – Please do NOT use previous applications. Please make sure ALL pages and forms are complete and signed/initialed as required. Incomplete applications will not be accepted and may delay acceptance into the program. Accepted applications missing signatures will significantly delay the check-in process.

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) **Fee for EXTRA shirts only**
- 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 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 AND SIGNED WITHIN 45 DAYS OF CAMPER ARRIVING AT CAMP – DO NOT SEND NOW – CAMPER MUST BE SEEN BY HEALTH PROVIDER WITHIN 45 DAYS OF ARRIVAL AT CAMP

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. **All 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 individual dose packs or bubble packed – 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:

- **April 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



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):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Metabolic Disorder | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Prader Willi Syndrome | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Other (Please List) | | |

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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Self-Injury | <input type="checkbox"/> Spitting | <input type="checkbox"/> Biting | <input type="checkbox"/> Property Destruction |
| Elopement: | <input type="checkbox"/> Physical Aggression
(kicking/hitting/punching) | <input type="checkbox"/> Inappropriate Language | <input type="checkbox"/> Not Following Directions |
| <input type="checkbox"/> Running Far Away | | <input type="checkbox"/> Sexual Acting Out | <input type="checkbox"/> Yelling |
| <input type="checkbox"/> Leaving the Area | | | |
| <input type="checkbox"/> 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:

Please describe any behavior triggers (e.g. loud noises, being touched):

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):

- | | | | |
|-----------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Verbally | <input type="checkbox"/> Sign Language | <input type="checkbox"/> Electronic Device | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> 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:

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> 2-person Lift | <input type="checkbox"/> Hoyer Lift | <input type="checkbox"/> 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 Yes No
(e.g. physical touch, activities, foods)

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: Camper may participate _____ (initial)

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: _____

In the last 12 months, has the camper tested positive for COVID-19? Yes No Date: _____

Has the camper had a COVID-19 vaccine? Yes No Date(s): _____ Brand: _____

Is the camper planning to receive a COVID-19 vaccine prior to camp?* Yes No

*Campers 16 and over MUST be fully vaccinated prior to attendance at camp

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 returned prior to attendance.

Type of seizures

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

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? Yes No If yes, please explain:

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

Please Describe Any Additional Medical Concerns:

Camper’s Name: _____

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

Information on this page will be verified and witnessed by Easterseals staff at check-in.

DON'T FORGET

Include a copy of insurance card (front and back) or Medicare/ Medicaid card with this form.

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: _____

Due to smaller session size and considerations for social distancing due to COVID-19 space is limited for each session. Campers may apply for more than one session but must indicate their first choice and may be placed on a waiting list for subsequent sessions. Age groups are a guideline for providing an age-appropriate experience. Speak to camp director for adjustments needed.

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

1. Payment By Session
2. Add in \$50 supply fee for FIRST session and \$30 for EACH additional session
3. Add in \$17 for each EXTRA tee shirt you order (ONE white and ONE color t-shirt are part of the supply fee)
4. Subtract \$150 from the FIRST session if paying IN FULL by April 15th
5. Then total all lines at bottom:

Mark "✓" below to make your reservation

Summer 2021 Sessions	First Choice		Session Rate	Fee
Session 1 – June 13-25, 2021 (18 and up)	<input type="checkbox"/>	<input type="checkbox"/>	\$2046.00	= \$
Session 2 – June 27- July 9, 2021 (18 and up)	<input type="checkbox"/>	<input type="checkbox"/>	\$2046.00	= \$
Session 3 – July 11-17, 2021 (18 and up)	<input type="checkbox"/>	<input type="checkbox"/>	\$1023.00	= \$
Session 4 – July 18-24, 2021 (16-24 years)	<input type="checkbox"/>	<input type="checkbox"/>	\$1023.00	= \$
Session 5 – July 25-31, 2021 (Under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	\$1023.00	= \$
First Session Supply Fee (Includes T-Shirt)			\$50.00	= \$
Additional Session Supply Fee			\$30.00	= \$
Early Bird Discount – First Session Only*			- \$150	= \$ *Paid in Full by April 15th
TOTAL DUE			\$	
First Session Deposit			\$350.00	= \$
Each Additional Session Deposit			\$330 x No. of Sessions	= \$
*Additional discounts may be added for payment in full if accepted into additional sessions			Total Due	= \$
			Deposit Due	= \$
A \$350 deposit for the first is required to hold the session. A deposit of \$330 is required for each additional session . Deposits are non-refundable once camper is accepted into the camp program.				

Will you be applying for Financial Aid? Yes (Income documentation required) No

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 Easterseals 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 2021 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. **This year, the camp supply fee includes ONE white and ONE color shirt.** A place for your name to be written will be on the left sleeve with "2021" below. All T-Shirt orders include a white shirt to tie-dye at camp. If you would like to order EXTRA shirts, complete the order form below and return the appropriate fee with your application.

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

Camper Name: _____

T-Shirt Size: _____

EXTRA T-Shirts: (Please write number of each size you would like)

Child S (\$17) _____	Adult S (\$17) _____	Adult XL (\$17) _____
Child M (\$17) _____	Adult M (\$17) _____	Adult 2XL (\$17) _____
Child L (\$17) _____	Adult L (\$17) _____	Adult 3XL (\$17) _____

Include payment for t-shirt with your application.

Please add the appropriate amount based on the number of T-Shirts ordered.

Total T-Shirt Amount: _____

T-Shirts will not be ordered until payment has been received.

Payment Options	<input type="checkbox"/> By Check/Money Order	<input type="checkbox"/> By Credit Card:
	Make checks payable to Easter Seals Florida	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express
	Mail to: Easter Seals Florida - Camp Challenge 31600 Camp Challenge Road Sorrento, FL 32776	Credit Card # _____ v-code# _____ Exp. Date ____/____/____ Card Holder Name _____ Signature _____
<input type="checkbox"/> 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



Campers Using CDC+ Funding

**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 responsibility 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 **April 15th**. You will receive determination by March 31st. Any Financial Assistance applications and required documents received after April 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: _____

Client 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 Rikeshia 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 _____

Print Name, Individual/Personal Representative _____

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 FORM



(To be completed by a Licensed Physician – 2 pages, Page #15 and 16 of the 18 page application)

This form must be signed by a licensed provided no more than 45 days prior to camper’s arrival at camp for the first session the camper is registered.

Camper’s 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: _____

IMMUNIZATION HISTORY

Does the camper have all the recommended vaccines? Yes [] No [] Date of last Tetanus: _____

If no, explain _____

****All campers 16 years and older MUST be fully vaccinated for COVI-19 prior to attendance.****

COVID vaccine date(s): _____ Brand: _____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP:

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

CURRENT OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP: (Vitamins, OTC Allergy Medication, etc.)

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*****

Physician’s Signature: _____ Date: _____

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 medications listed below

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Acetaminophen 325mg | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Barrier Cream (Zinc Oxide) | <input type="checkbox"/> Eye Drops (Visine) |
| <input type="checkbox"/> Diphenhydramine HCL | <input type="checkbox"/> Glycerin Suppository | <input type="checkbox"/> Antacid (Tums) | <input type="checkbox"/> Pepto Bismal |
| <input type="checkbox"/> Hydrocortisone Cream | <input type="checkbox"/> Triple Antibiotic Cream | <input type="checkbox"/> Aloe | <input type="checkbox"/> Nasal Decongestant |
| <input type="checkbox"/> Cold and Allergy Medicine | <input type="checkbox"/> Unisom (Sleep Aid) | <input type="checkbox"/> Bacitracin Ointment | |

ALLERGIES (Food, Medication, Plants, Insects) _____

Reaction Type

- Anaphylaxis Rash/Hives Upset Stomach Other: _____

DIETARY RESTRICTIONS Yes [] No []

If yes, explain:

SEIZURES: Yes [] No [] Type _____ Date of last seizure: _____

Known Seizure Triggers: _____ Medication Controlled? Yes [] No []

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

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)? _____

Comments:

PHYSICIANS STATEMENT

I have examined the camp applicant. In my opinion, the camper's disability or health condition:

Allows [] Does Not Allow [] his/her participation in an active camp program. The camper is specifically able to participate in the following activities:

[] Swimming

[] Outdoor Activities lasting 45-60 minutes

Licensed Physician's Signature

Physician Name (printed)

Date of Most Recent Examination

Physician Address: _____

City _____ State _____ Zip Code _____

Phone: () _____



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 Rikeshia Blake. You can contact the Privacy Officer at 407-588-7133.

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.

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 required 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 allowed 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.