Easterseals Camp Challenge
Part 1 - Camper Information
2024-2025 Camp Season

Please fill out the application in its entirety with as much detail as possible. Campers are accepted into the program based on the information provided on the application, the medical form signed by the doctor, and previous camp experience. Failure to disclose information in the application process may result in a camper being removed from the program due to the level of care required. This application is required for overnight summer camp, weekend camp, and weeklong camp programs and must be completed once each year.

****Be sure to complete all sections and answer all questions –**

blank spaces will be considered an incomplete application and will delay the acceptance process**

GENERAL INFORMATION

Camper's Full Name:_____

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

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

Phone: (_____)_____ Camper's Email: _____

Camper T-Shirt Size: _____ 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:** (MUST HAVE ALTERNATIVE CONTACT)
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
Pease refer to page 3 of the welcome letter for criteria for a 3:1 ratio

Disability (please check all that apply):

☐ Down 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) _____

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:

_____
_____

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):

☐ 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

Notes on transferring:

_____
_____

Eating: ☐ Yes ☐ No

Does camper require special feeding (i.e. G-tube)

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 the camper use a CPAP or BiPAP machine? ☐ Yes ☐ No

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 ☐ 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: Camper may participate _____ (initial)

Please note the pool is 4.5 feet deep in the middle and 3.5 feet deep at each end. A lifeguard is always on duty. Campers are accompanied by staff in the pool at all times.

Please check all that apply regarding camper's swimming ability.

☐Swims well without assistance ☐Swims w/ assistance/flotation device ☐Stands in water or sits on stairs

Other information pertaining to swimming/pool including equipment needed (life jacket, innertube, etc.):

_____

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 w/Nerf darts): 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 Course: Camper may participate _____ (initial)

Has the camper ever done a challenge course (low-to-the-ground) before? ☐ Yes ☐ No

Does the camper have issues/concerns with balance? ☐ 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 limitations 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

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 or Behavioral Concerns:

_____
_____

Acknowledgement and Attestation

Camper's Name: _____

This application is complete and accurate to my knowledge. I understand information provided will be used to make a decision on acceptance into the camping program. Omitting information or providing inaccurate information may result in the camper being removed from the camping program. Fees paid are non-refundable. The camper may be prohibited from participation in future camping programs with Easter Seals Florida, Inc.

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

Relationship to Camper: _____ Phone #: (_____) _____

CAMPER NAME:_____

Part 2 – Session Registration for WEEKEND & WEEKLONG CAMP 2024-2025
Fee Worksheet

THIS FORM MUST BE COMPLETED FOR EACH CAMPER

Please complete the fee chart below to determine camper's total fee. Once completed, you may contact the office to register for additional weekend camp sessions.

Campers of all ages six and up are eligible for weekend and weeklong camp programs

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

Weekend Camp Session 2024-2025			Rate	Fee
Weekend 1	October 25-27, 2024 (Friday-Sunday)	2 nights	$475	$
Weekend 2	November 22-24, 2024 (Friday-Sunday)	2 nights	$475	$
Weekend 3	January 17-20, 2025 (Friday-Monday)	3 nights	$685	$
Weekend 4	February 14-17, 2025 (Friday-Monday)	3 nights	$685	$
Weekend 5	April 25-27, 2025 (Friday-Sunday)	2 nights	$475	$
Weekend 6	June 6-8, 2025 (Friday-Sunday)	2 nights	$475	$
Down syndrome	August 1-3, 2025 (Friday-Sunday)	2 nights	$475	$
Weeklong Camp Sessions 2024-2025			Rate	Fee
Winter Camp	December 15-21, 2024 (Sunday-Saturday)	6 nights	$1325	$
Spring Camp	March 9-15, 2025 (Sunday-Saturday)	6 nights	$1325	$
		TOTAL DUE		$
		BALANCE DUE 14 DAYS PRIOR TO FIRST SESSION ATTENDING		
A $200 deposit **per session** is required to hold the session. Deposits are non-refundable once camper is accepted into the camp program.				Deposit Enclosed $
Campers may make "pre-payments" toward their session(s) at any time beginning September 1, 2024.				

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*

CAMPER NAME:_____

Part 2 – Session Registration for OVERNIGHT SUMMER CAMP 2025
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 total fee, even if you are applying for financial aid. Financial aid is limited, dependent on availability, and not guaranteed.

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

1. Payment By Session
2. Subtract $150 from EACH session if paying IN FULL by **February 15th**
3. Then total all lines at bottom:

Weekend Camp Session 2024-2025			Rate	Fee
Session 1	June 15-21, 2025 (Sunday-Saturday)	6 nights	$1325	$
Session 2	June 22-July 4, 2025 (Sunday-Friday)	12 nights	$2625	$
Session 3	July 6-12, 2025 (Sunday-Saturday)	6 nights	$1325	$
Sibling Week	July 6-10, 2025 (Sunday-Thursday)	4 nights	TBD	
Carryover Night	July 12-13, 2025 (Saturday-Sunday)	1 night	$250	$
Session 4	July 13-19, 2025 (Sunday-Saturday)	6 nights	$1325	$
TOTAL DUE ***FEBRUARY 15, 2025 IF USING THE EARLY BIRD DISCOUNT (Subtract $150 per Session)**				$
A $350 deposit **per session** is required to hold the session. Deposits are non-refundable once camper is accepted into the camp program.				Deposit Enclosed $
Campers may make "pre-payments" toward their session(s) at any time beginning September 1, 2024. If full payment is received by 2/15/2025 the Early Bird Discount of $150 per session will apply. If full payment is NOT received by 2/15/2025 the full-session fee must be paid.				

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*

CAMPER NAME:_____

Campers Using CDC+ Funding

- A CDC+ Authorization must be provided. Client CDC Number:_____
- 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.

Payment Information

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 _____ Amount to be Charged: _$_____
	☐ **Pay by phone:** Contact the Camp Office at 352.383.4711 Monday to Thursday between 9:00 am and 3:30 pm.	

Easterseals Florida 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 May 1st. 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 ONLY**

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: _____

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 Number: _____

Policy Holder: _____ Certificate Number: _____

SSN#:_____ 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.

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

If your camper is transported by EMS to a hospital while at camp, you MUST make arrangements to meet them at the hospital within 1 hour (plus driving time). Camp is not responsible for transporting the camper back to the camp facility; a legal guardian must make transportation arrangements.

CAMPER NAME:_____

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 to Use/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 Rob Porcaro, 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:

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Signature Printed Name and Title