Easter Seals Camp Challenge
Weekend Respite Camp Application

We are delighted to give you the Easter Seals Camp Challenge 2016 - 2017 **weekend respite 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 Note: There will be four (4) upcoming Weekend Respite Camps – **Fall** (October 7-9, 2016), **Winter A** (December 9-11, 2016), **Winter B** (February 10-12, 2017) and **Spring** (April 21-23, 2017). See Page 5 – Fee Section for pricing and how you can receive a discount of over $100!

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

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

- ☐ This Checklist – Page 1
- ☐ Completed Application form with legal guardian signature(s) – Pages 2-4
- ☐ Fee and Payment Information with Signatures – Page 5
- ☐ Media Release form – Page 6 **(new campers only)**
- ☐ Medical and Liability release/Insurance information form – Page 7 **(new campers only)**
- ☐ For all campers that **did not** attend Camp Challenge summer camp in 2016 **Camper Medical Form** This must be completed by a licensed physician. - Pages 8-9
- ☐ Privacy Practices (DO NOT RETURN – KEEP FOR YOUR RECORDS) – Pages 10-11
- ☐ Check made payable to "**Easter Seals Florida, Inc.**" for full amount.

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. **Please note: We cannot fully process an application and confirm acceptance to the program without full payment and a completed application packet. For our record keeping purposes all applications must be fully completed with all questions answered. Incomplete applications will be returned and acceptance into the program will not be guaranteed.**

Email: camp@fl.easterseals.com or Phone: (352) 383 – 4711

www.easterseals.com/florida

EASTER SEALS CAMP CHALLENGE CAMPER APPLICATION

PLEASE COMPLETE THE FOLLOWING APPLICATION

Weekend Respite Camp Dates	Mark "✓" below to attend
Check-in Friday – 3:00pm-4:30pm (dinner will be served)	Check-out Sunday – 3:00pm-4:00pm (lunch will be served)
☐ Friday, October 7 – Sunday, October 9, 2016	☐ Friday, December 9 – Sunday, December 11, 2016
☐ Friday, February 10 – Sunday, February 12, 2017	☐ Friday, April 21 – Sunday, April 23, 2017

Section I: General Information

Camp Challenge

Camper's Full Name:_____

Address: _____

Street City State Zip County

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

Phone: (_____)_____ **Email:** _____

Caregiver Email if Different:_____

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

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

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

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

For New and Returning Campers - Please answer all questions below.

Campers that attended Camp Challenge for Summer Camp 2016 – please complete all questions and note any changes.

Does camper have any behavioral concerns? ☐ **Yes** ☐ **No**

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:

_____

_____

Does camper have any routines that are significant for camp staff to be aware of? ☐ **Yes** ☐ **No**

If yes, please explain:

_____

_____

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:

_____

_____

Does the camper have any bedtime rituals or routines? ☐ Yes ☐ No
If yes, please explain: _____
_____

Does the camper use bedrails? ☐ Yes ☐ No

Does the camper have any adaptive equipment (ex. Life jacket) to assist with participation in activities? ☐ Yes ☐ No
If yes, please explain: _____
_____

Swimming: Please check all that apply regarding camper's swimming ability.
☐ Swims well without assistance ☐ Swims with assistance ☐ Non-swimmer
Other information pertaining to swimming/pool: _____
_____

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

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: _____
_____

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

Health History

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]

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):
_____
_____
_____

Adaptive Equipment: **Does camper use any of the following? (Check all that apply)**

☐ **Glasses** ☐ **Hearing Aids** ☐ **Orthotic Leg Braces** ☐ **Dental Retainers/Devices** ☐ **Walker/Cane**
☐ **Wheelchair (☐ Electric / ☐ Manual)** ☐ **Other** _____

Special Instruction: _____

_____

Medications:

☐ **List any medications and the times given on the Camper Medication Record Form included.**

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: _____

Physician's Name: _____ Phone # ( ) _____

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

Relationship to Camper: _____ Phone #: ( ) _____

Section 2: Fees and Payment

Total Fee is $300 for each weekend camp session– full amount must be paid with application – No financial aid is available.

OR

Multi-Weekend Discount Available – Camp Challenge will be offering four upcoming weekend respite camps:

- **Fall- October 7-9, 2016**
- **Winter A- December 9-11, 2016**
- **Winter B- February 10-12, 2017**
- **Spring- April 21-23, 2017**

Respite Sessions	4 Prepaid Camp Sessions	3 Prepaid Camp Sessions
Cost	$1,032.00	$837.00
Savings	**-$168.00**	**-$63.00**

- **If a camper registers and attends all four (4) weekend respite camp sessions, the discounted total is $1,032. This is a savings of $168, however ALL WEEKEND RESPITE CAMPS MUST BE PAID IN FULL PRIOR TO THE START OF THE 1st ATTENDED WEEKEND RESPITE CAMP.**
- **If a camper registers and attends three (3) weekend respite camp sessions, the discounted total is $837. This is a savings of $63, however ALL WEEKEND RESPITE CAMPS MUST BE PAID IN FULL PRIOR TO THE START OF THE 1st ATTENDED WEEKEND RESPITE CAMP.**

By signing below I acknowledge:

- **All camp fees are non-refundable once camper is accepted to the weekend respite 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, the deposit check, and any other funds, will be returned in full.**
- **That if camper fails to complete a weekend respite camp session no refund will be given.**
- **That all camp fee payments will be forfeited for campers who fail to attend assigned session(s).**

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

Make Checks payable to Easter Seals Florida and mail to:

Easter Seals Florida - Camp Challenge
31600 Camp Challenge Road
Sorrento, FL 32776

- -

Or pay by credit card:

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Credit Card # _____ v-code# _____ Exp. Date _____/_____

Card Holder Name _____ Signature _____

Or to pay by phone:
Contact the Camp Office at 352.383.4711
Monday to Thursday between 9:00 am and 3:30 pm.

☐ **I am a returning camper. Skip this page.**

MEDIA RELEASE

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easter Seals Florida or its respective employees and agents may be used by Easter Seals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easter Seals Florida and that these materials may be released to the general public. I assign to Easter Seals Florida all of my rights to these materials.

I understand that these materials made by Easter Seals Florida, its employees and agents are owned by Easter Seals Florida and that they may copyright them. I will allow Easter Seals Florida, their respective employees and agents, and those acting with Easter Seals Florida's permission, to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easter Seals Florida and to release this information to the general public.

I understand that these materials may be published on Easter Seals Florida's network of websites & social media sites and this may disclose my personal and protected health information online.

Easter Seals Florida does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easter Seals Florida may decide not to use them.

I acknowledge that the rights described above are granted to Easter Seals Florida on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easter Seals Florida will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easter Seals Florida to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easter Seals Florida in writing by sending my revocation to **Susan Ventura, President/CEO Easter Seals, Florida Inc**. I understand and agree that once Easter Seals Florida, its respective employees and agents, and those acting with its permission, disclose my protected health information as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires three years from the date of my signature below.

I have read this release and authorization before signing below, and I fully understand its contents.

Camper Name (Print): _____

_____

Signature of Parent/Guardian

_____

Printed Name of person signing on above line

_____

Date

☐ **I am a returning camper. Skip this page.**

MEDICAL AND LIABILITY RELEASE/INSURANCE INFORMATION

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

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

Easter Seals 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 Easter Seals Florida's Notice of Privacy Practices. _____

(Please Initial Here)

I release and completely discharge Easter Seals 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 Easter Seals 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. Easter Seals Florida, Inc. and/or its representatives, agents, employees, officers, directors, volunteers, consultants or contractors.

If I am injured, I agree not to sue Easter Seals 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

EASTER SEALS CAMP CHALLENGE

NEW CAMPER MEDICAL FORM

(To be completed by a Licensed Physician – 2 pages)

NOTE: If Camper attended summer camp 2016 at Camp Challenge, then you do not need to have this completed. All other campers must have this completed by a licensed physician.

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 (Please record dates of basic or most recent booster)

VACCINE	MONTH/YEAR	VACCINE	MONTH/YEAR
DTP		**TD** (Tetanus/Diphtheria)	
Polio		**Date of last Tetanus**	
MMR		**Varicella (Chicken Pox)**	
Haemophilus Influenza B		**Tuberculin Test**	
Hepatitis B			

CURRENT "OVER THE COUNTER" MEDICATIONS TO BE TAKEN AT CAMP: (Please also include medications taken on as "as needed basis" for headaches, upset stomach, bug bites etc).

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

Date:_____ **Physician's Signature:**_____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP:

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

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

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

Seizure Triggers: _____ Medication Controlled? (list) _____

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's disability or health condition:
Does [ ] Does Not [ ] preclude his/her participation in an active camp program.

_____ _____

Licensed Physician's Signature Physician Name (printed)

_____

Date of Most Recent Examination

Physician Address: _____

Phone: ( ) _____

CAMPER/LEGAL GUARDIAN COPY-DO NOT RETURN WITH PACKET

EASTER SEALS FLORIDA

NOTICE OF PRIVACY PRACTICES

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 407-306-9766.

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 <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.