Easterseals Summer Academy

Thank you for your interest in our summer program. Our goal is to ensure that your family's participation in our program is a positive and empowering experience. Please take the time to review and complete the documents we have provided in this packet. Please note that there will be a deposit required of $200 to secure your spot. If you pay for the entire summer, there will be a 10% discount.

Summer Academy Day Camp Dates/Times

June 6th-August 5th (Closed July 4th)

Monday – Friday 8:30AM-3:30PM

Cost

$200/week

10% Discount if sign up for the whole summer

Summer Day Camp Activities

1) Adaptive Culinary Lessons
2) Adaptive Cricut Classes
3) Adaptive Photoshop Classes with certificates earned
4) Adaptive Camera Use Classes
5) Adaptive 3D Printing Classes with certificates earned
6) Arts/Crafts
7) Field Trips in Easterseals Van

Contact Information

Catrina Sanchez, Center Director

P 239.403.0366 • C 813.391.1755

CSanchez@fl.easterseals.com

In the case of shared custody, a signature from both parents is required on all documents.

HIPAA – PRIVACY POLICY

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your family member's privacy. HIPAA outlines the strict **Federal** rules and regulations regarding the ways in which an individual's Protected Health Information (PHI) must be protected. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Easterseals strictly adheres to the following policies:

1. **Release of Information:** A signed Release of Information Form must be on file prior to communicating with any outside service provider or non-authorized family member about a student. Student information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to our student's care are handled appropriately. It is understood and agreed that this is a normal protocol and procedure utilized within the office for the handling of charts, student records, PHI and other documents or information.

2. **Staff:** All Easterseals staff complete HIPAA training and are strictly prohibited from discussing student information with anyone other than a parent or guardian of the student they are working with and appropriate School staff. They may not share any school information nor can they acknowledge the presence of another individual/family enrolled in School services.

3. **Email:** Emailed student information to Easterseals is not protected. We can communicate with families through secured email and will not send any protected information about the student via unsecured email.

4. **Fax:** Student information is only protected when it is faxed to and from a private landline from and to a dedicated fax machine.

5. **It is understood and agreed** that inspections of the office and review of documents including government agencies or insurance payers may occur.

6. **Confidential information** will not be used for the purposes of marketing or advertising.

7. **It is understood and agreed** to bring any concerns or complaints regarding privacy to the attention of the Privacy Officer, Rob Porcaro at (561)422-9568.

8. We agree to provide clients with access to their records in accordance with state and federal laws.

9. 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.

Student's Name_____

➡ ***Signature***_____***Print***_____***Date***_____

➡ ***Signature***_____***Print***_____***Date***_____

easterseals Florida **Easterseals Summer Academy**

School Application

STUDENT INFORMATION: (Please print clearly)

Child's Name_____ DOB_____ Age_____

Parent:_____	**Parent:**_____
☐ Child's Primary Address	☐ Child's Primary Address ☐ Same
Address:_____	Address:_____
_____	_____
Cell:_____	Cell:_____
Home:_____	Home:_____
Work:_____	Work:_____
Email:_____	Email:_____
Employer:_____	Employer:_____
Occupation:_____	Occupation:_____
Marital Status: _____	Marital Status: _____

Diagnosis: _____

FAMILY INFORMATION: PARENT/S and GUARDIAN/

Emergency Contact_____Relation_____ Phone_____

Emergency Contact_____Relation_____ Phone_____

In the case of shared custody, a signature from both parents is required on all documents.

PLEASE LIST ALL INDIVIDUALS EASTERSEALS MAY COMMUNICATE WITH REGARDING YOUR CHILD
(Grandparent, nanny, babysitter, cousin, aunt, etc)

Name	Relation	Phone

_____ _____ _____
Parent/Guardian's Signature ***Print*** ***Date***

_____ _____ _____
Parent/Guardian's Signature ***Print*** ***Date***

In the case of shared custody, a signature from both parents is required on all documents.

Emergency Release for Treatment

I authorize all medical and surgical treatment, X-Ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent/Guardian's Signature_____***Print***_____***Date***_____

Parent/Guardian's Signature_____***Print***_____***Date***_____

Hospital/Clinic Preference:
Diagnoses (Medical &Psychiatric):
Allergies/Dietary Restrictions:
Current Medications/Dosage/Frequency:
Current over-the-counter medication and/or vitamins:
Primary Care Physician's Name/Number:

easterseals Florida **Easterseals Summer Academy**

ENVIRONMENT

Who does your child live with_____

If shared custody, please list schedule_____

Name and Age of Brothers/Sisters_____

_____

Are there any family members or friends that are often in the home or caring for your child _____

_____

Pets in the home _____

Any information regarding child's behavior: _____

_____

MEDICAL HISTORY

Family or Medical History that would be important for Easterseals to know?

_____

_____

_____

List any allergic reactions that your child has a past or current history of		Past	Current	Please Explain
Medications				
Environmental				
Dietary Restrictions				

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

Date: _____

Name: _____ Birth Date: _____

_____
Street Address Apt #

_____
City State ZIP

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

Authorization

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

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

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

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

printed materials, web sites and social media.

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

I understand

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

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

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

To be completed by Easterseals Florida staff:

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Easterseals Florida
by:

_____

Signature Printed Name and Title