Office use only:

Easterseals Iowa Camp Sunnyside
-Spring Break Application 2019-

Are you privately paying? ☐ **YES** ☐ **NO** *If yes, you will receive an invoice.*

Client Information (Please Print Legibly)		
Last Name:	First Name:	Middle Name:
Address:		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	
Social Security Number:		Medicaid ID:
Gender: ☐ Female ☐ Male		Birthdate: / /
Primary Language: ☐ English ☐ Spanish ☐ Other_____		

Guardian Information		
First Name:	Last Name:	Relationship:
Address:		
City/State:	County:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email:		Interpreter: ☐ Yes ☐ No
Primary Language:	Preferred Method of Contact:	

Are you new to Camp Sunnyside? ☐ Yes ☐ No

If your are a new camper, please list any additional support needs you may have:

Please note: after submitting this information, a member of our staff may be in contact with you to obtain additional support information

- ☐ Needs Assistance with Personal Cares (toileting, hygiene, dressing)
- ☐ Needs Assistance with Ambulation
- ☐ Uses a Wheelchair
- ☐ Stays with the Group
- ☐ Wanders Away from the Group
- ☐ Actively Leaves the Group
- ☐ Can be supported in a 1:5 ratio
- ☐ No Additional Support Needs

Other Support Needs (Please specify):

Please mark all activities that are RESTRICTED:

☐ Swimming	☐ Basketball
☐ Boating	☐ Dancing
☐ Sensory Room	☐ Arts and Crafts
☐ Climbing Wall	☐ Archery
☐ Outdoor Camping	☐ Outdoor Cooking/Campfires
☐ Horseback Riding	☐ Volleyball
☐ Fishing	☐ Zip Line
☐ Adventure Tree Climbing	☐ No Restricted Activities

Please explain why these activities are restricted:

Dietary Information

Are you n a special diet? ☐ Yes ☐ No

If yes, please list they type of special diet:

Allergies

Does the Camper need an Epi Pen?	☐ Yes ☐ No If yes, please explain:
Food Allergies:	
Reactions:	
Other Notes:	
Other Non-Food Allergies:	
Reactions:	
Other Notes:	

Seizures

Do you have a seizure disorder? Yes ☐ No ☐ **(if yes, please fill out the rest of this section)**
VNS: ☐ Yes ☐ No

What type of Seizures?	Date of Last Seizure:
Frequency:	Seizure Time/Length:
Known Triggers:	
Behavior / Aura Prior to Seizure:	
Type of Behavior During Seizure:	
Recovery Time / Behavior After Seizure:	
Medical Intervention Plan:	Rescue Med: ☐ Yes ☐ No
Do you use a safety helmet? Yes ☐ No ☐	

Please List Three Emergency Contacts

Name:_____ Relationship:_____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Name:_____ Relationship:_____

Work Phone: _____ Home Phone:_____ Cell Phone:_____

Name:_____ Relationship:_____

Work Phone: _____ Home Phone:_____ Cell Phone:_____

Preferred Hospital:

Have you sent in a physical within the last 2 years? ☐ Yes ☐ No

Last Tetanus Booster Date (We must know the camper's last tetanus booster date in order to be registered to attend camp)

By signing here, you give our healthcare staff the permission to provide routine healthcare, dispense medications, and seek emergency treatments.

Application Completed By: _____ **Date:** _____

(Print)

Relationship: _____

Signature of Legal Guardian: _____

(Must have guardian signature.. If camper is their own guardian camper must sign.)

-WAIVER OF LIABILITY-

Signature Required

Client Name:_____ Program Name:_____

With the understanding that Easterseals Iowa (hereafter known as ESI) will make reasonable efforts to prevent accidents, injuries, or other mishaps, I acknowledge the following:

The undersigned, individually or as a parent or natural guardian, in partial recognition of services rendered claims, demands, or actions, causes of action or suits of whatsoever kind or nature for damages sustained by the normal client or accruing to the undersigned in consequence of any accident or occurrence resulting from the use of durable medical equipment and/or participation in any activity or program of ESI and regardless of whether the named client is not on the premises of said ESI, and is engaged in any venture or solely on his or her own behalf.

I give permission for the applicant to attend ESI sponsored programs and to ride in vehicles operated or leased by ESI.

I agree to not send this applicant to an ESI program if he or she has been exposed to contagious disease within three weeks of the starting date of the program and to notify Easterseals Iowa Camping, Recreation, and Respite services immediately if this situation arises.

The-applicant has permission to engage in all prescribed activities except those noted by an examining physician or physician assistant and me. In the case of an emergency or ill health, I herby give permission to the physician selected by ESI to order x-rays, routine test, and treatments. In the event I cannot be reached in an emergency, I herby give my permission to the physician selected by ESI to hospitalize, secure proper treatment for, to order injections and/or anesthesia and/or surgery for the named participant.

I understand that the participant is responsible for his/her own medical coverage and associated cost.

This release may be revoked in writing except to the extent action has been taken in reliance upon the release.

I understand and agree to the above section.

Signature of legally responsible person (parent, guardian, or applicant if own guardian):

Print Name:_____ Date:_____

Sign Name:_____ Relationship:_____

-Photo Consent Form

Select 1 box and Signature Required

Client Name:_____ Program Name:_____

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Iowa may be used by Easterseals Iowa, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Iowa and that these materials may be released to the general public. I assign to Easterseals Iowa all of my rights to these materials. All photographs and other media which include your image are the sole property of Easterseals Iowa. Such photos may be used at various times unless you revoke this photo consent in writing. Any revocation is valid from the date it is received by Easterseals Iowa and will not apply to photos that have been used prior to the revocation in any publication or other media.

I understand that these materials may be published on Easterseals Iowa's network of Web sites and this may disclose my personal and protected health information. To ensure the privacy of any person under age 18, Easterseals Iowa will use only the first name and the location of the Easterseals Iowa organization where a minor receives services. Easterseals Iowa does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easterseals Iowa may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals Iowa 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 Easterseals Iowa 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 Easterseals Iowa to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Iowa in writing by sending my revocation to Easterseals Iowa Intake/Marketing Coordinator. I understand and agree that once Easterseals Iowa, 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.

☐ **Yes -** please take and/or use my picture.

☐ **No -** please do not take and/or use my picture.

I fully understand the contents of this release and authorization.

_____ _____

Camper Signature Date

_____ _____

Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF THE EASTERSEALS IOWA INCORPORATED

NOTICE OF PRIVACY PRACTICES

Signature Required

I,_____, acknowledge that I have received a copy of The Easterseals Iowa Incorporated's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by Easterseals Iowa and states my rights with respect to my health information. I understand Easterseals Iowa has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Easterseals Iowa revises its information practices, a revised Notice will be posted at each Easterseals Iowa location and that I may obtain a current Notice of Privacy Practices at any time from the Easterseals Iowa State Office or the website at www.eastersealsia.org.

_____ _____

Signature of Client/Guardian/Representative Date Signed

_____

If Guardian/Representative - State relationship to client

Easterseals Iowa

-Physical Examination Form-

Client Name:_____ **Birthdate:**_____

This form is to be completed by a licensed physician or by a physician's assistant.
Other exam forms will not be accepted.

Height:_____ **Weight:**_____

BP:_____ **Pulse:**_____

	Normal	Abnormal
EENT		
Heart		
Lungs		
Resp.		
GI		
Abdomen		

State the most recent date of occurrence:

[ ] Chicken pox_____

[ ] Measles_____

[ ] German Measles_____

[ ] Mumps_____

[ ] Hepatitis carrier_____

[ ] Rheumatic Fever_____

Known allergies and reaction:_____

Epi-Pen? [ ] Yes [ ] No

	Yes	No	Please Explain
The applicant is under the care of a physician for a medical diagnosis/disability.			
The applicant can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, adventure tree climbing, and other outdoor activities			
The applicant has received a Tetanus Booster within the last ten years.			
Date of most recent Tetanus Booster: _____ **please attach all immunization records**			

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

_____ _____

Signature of examining physician or physician's assistant Please print name

Fax:_____ Telephone:_____

Date of Exam: _____ **Date Form Completed:**_____