Easterseals Iowa

Respite 2024 Packet

Please allow up to three weeks for processing

Only completed packets will be processed.

We will communicate via email. Please be sure to list a valid email

If you do not have access to an email, please call our Program and Support Specialist for accommodations at (515) 309-2375

Respite weekends are available for campers ages four years and older. Respite is a year-round program offering two weekend camps a month. Campers will check in on Fridays between 6:30pm-7:30pm, and will check out on Sundays from 3:00pm-4:00pm.

The following packet forms MUST be submitted together

___ 2024 Application- **all sections must be filled out for the packet to be considered "complete"**

___ Release Forms *(Notice of Privacy Practices, Waiver of Liability, Rights and Responsibilities, Photo Consent, Message Consent)*

___ Physical (valid for 2 years from exam date) + immunization records (Requires non-electronic *signature*

___ Medication List (Please still indicate if no current medications)

*If using waiver funding, waiver documents are not required to be submitted with application

You may send them to our Program and Support Specialist, by the following methods:

Email: campandrespite@eastersealsia.org

Mail or Drop Off: Easterseals Iowa
Attn: Camp and Respite
401 NE 66th Ave
Des Moines, IA 50313

Fax: 515-289-1281

We will notify you by email when your packet has been received, and again when processed. Please contact the Program and Support Specialist 515-309-2375 or campandrespite@eastersealsia.org if you have any questions.
Thank you for choosing Easterseals Iowa!

2024 Respite Information

The Easterseals Iowa Respite program provides temporary care for children and adults with disabilities for ages four and older. Respite is a non-goal oriented program that allows caregivers a break while providing their loved ones with a safe and supported environment

Regularly scheduled respite weekends are held at Camp Sunnyside. This year-long program offers two weekend respites a month. Respite campers participate in all the activities that Camp Sunnyside has to offer! This includes boating, swimming, horseback riding and much more.

Easter Seals Camp Sunnyside

If you are new to Easterseals Iowa/Camp Sunnyside, or have not attended camp within the last two years, our intake coordinator will contact you to further discuss your packet.

Keep this page for your records

Quarterly Respite Registration

Only completed application packets will be allowed to register quarterly.

Registration is separate from the application packet

Registration request form link: www.eastersealsia.com/ia/respite

Registration request forms:

Registration for Respite weekends will be completed online, on a quarterly basis. All forms will be processed on a first-come-first-serve basis. The online quarterly registration will open on the first of each month, one month prior to the start of the new quarter. The registration will close on the 15th of each month, one month prior to the start of the new quarter. (i.e. Quarter 1: January-March, registration request forms **open** December 1st 12:00am and will **close** December 15th 11:45pm.) You will not be able to submit online registration requests prior to the first of the month. You will receive an email confirming the dates you are registered for within three weeks of submission. You will be notified if any of your requested dates are full, and we will provide any available alternate dates. Specific dates can be found on the website.

1:1 support services:

Quarterly registration will be processed on first-come-first-serve basis. Please allow for three weeks to process all requests. You will receive an email confirming dates requested, by the 20th of the month prior to the start of the new quarter. Specific dates can be found on the website.

Cancellation Policy:

The Camp and Respite Department require that all cancelations are received, via email or phone call, a minimum of 24 hours prior to your registered check in time. The second violation of this policy could result in the removal of the participant from their registered weeks for the remaining quarter.

If you have questions, please contact our Camp and Respite Program and Support Specialist at campandrespite@eastersealsia.org or (515)309-2375. Additional information may be found on our website,www.eastersealsia.com/ia/respite or in the Camp Sunnyside Participant Handbook

Thank you for choosing Easterseals Camp Sunnyside!

Keep this page for your records

If you are using **Waiver Funding:**

- **Please contact your case manager before sending in the application.** We ask that you discuss the number of camp sessions you are interested in, what type(s), and which dates the camps occur, to ensure proper funding will be provided. Funding must be submitted prior to attending.
- Contact our Program and Support Specialist if there are barriers with the case manager being able to submit funding and care plan to Easterseals within the requested time frame.
- Please send any available funding and billing information with the application to our Program and Support Specialist.
- **Please Note:** The entire unit amount per camp is required to be authorized by the waiver, even if the camper will not attend the entirety of the camp. Easterseals will only bill for the amount of time your camper participates in programming.

Easterseals Iowa

Email: campandrespite@eastersealsia.org

Attn: Camp and Respite
401 NE 66th Ave
Des Moines, IA 50313

Fax: 515-289-1281

Current Waiver Rates

Weekend Respite Non CMH: T2036	**Weekend Respite CHM: T2036**
$3.41unit	$3.61/unit
184 units per weekend	184 units per weekend

Private Pay: $665 per weekend

Easterseals Iowa Camp Sunnyside

Respite Application 2024

Office use only
Date and Time Received _____
Date Notified _____

Are you privately paying? [ ] YES [ ] NO

If so, it is $665 full payment, per weekend.

Please mark this box if your camper utilizes any 1:1 services ☐

Camper Information (Please Print Legibly)		
Last Name:	First Name:	Middle Name:
Address:		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	
Social Security Number:		Medicaid ID:
Email:		Birthdate: / /

Gender: ○ Female ○ Male Preferred Pronoun: ○ He ○ She ○ Other If Other:_____

Preferred Language:

Ethnicity: ○ Asian American ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Multiple Ethnicities ○ Choose Not to Say ○ Other: _____

Military Status: ○ Active ○ Member of Military/Vet Family ○ National Guard/Reserve ○ Veteran ○ N/A

Waiver Designation:

○ Brain Injury	○ Brain Injury + DD	○ Children's Mental Health
○ $100% County Case Management	○ DD Case Management	○ Elderly
○ Health and Disability	○ Health and Disability + DD	○ HIV/AIDS Waiver
○ Intellectual Disability	○ Physical Disability	○ Physical Disability + DD

Employments

Is the camper employed? [ ] Yes [ ] No

1. Emergency Contact		
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:	

2. Emergency Contact

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:	

Health Information

Which Managed Care Organization (MCO) are you using?

○ Iowa Total Care ○ Amerigroup ○ HIPP/IME ○ Molina

Managed Care Policy Number:

Case Manager: Phone: Fax:

Agency: Email:

Address: City/State: Zip Code:

Legal Guardian (Camper 18+ Only)

Name:

Phone:

Preferred Hospital (In the event of an emergency)

○ Broadlawns ○ Mercy Medical ○ Unity Point—Lutheran ○ Unity Point—Methodist

○ Unity Point Blank Children's ○ Other_____

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 [ ]	

Medical Diagnosis

Primary: (please circle)

Brain Health (mental illness)	*Cerebral Palsy*	*Scoliosis*	*Brain Injury*
Autism	*Epilepsy*	*Spina Bifida*	*Fetal Alcohol*
Alcoholism/Drug Abuse	*Heart Disease*	*Cleft Palate*	
Other Psychological Disorders	*Asthma*	*Down's Syndrome*	
ADD/ADHD	*COPD*	*Speech, Language & Voice Dysfunction*	
Developmental Delays	*Diseases of the skin & tissue*	*Spinal Cord Injury*	
Intellectual Disability	*Arthritis*	*Head Injury*	

Secondary:

Other:

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:	

Personal Hygiene (Brushing teeth, shower etc.)

Level of Assistance Needed: ○ Independent ○ Some Assistance ○ Total Assistance [ ] Verbal Prompt

Detail of level of Assistance:

Dietary Information

(Please mark all that apply)

Eating: ○ Eats Independently ○ Total Assistance
[ ] Monitor Portions [ ] Help Cutting Up Food

Are you on a special diet? ○YES ○NO

○ **G-Tube?** If so, are you NPO? ○Yes ○No
Please add feeding schedules to medication list
○ Mechanical Soft
○ Pureed
○ Fluid Restriction required per Physician
○ Other _____

Are you Diabetic? ○ Yes ○ No
[ ] Medication Controlled
[ ] Diet Controlled
[ ] Carb Count - How many Carbs? _____
[ ] Insulin Controlled
Please add blood sugars check times to the medication list

Notes:

Assistive Technology

(Select all that apply)

○AFO/KAFO ○Aug/Alt Communication Device ○ Bed Rails ○Grab Bars ○Hospital Bed ○Shower Chair
○Other Bathing Aid ○Gait Belt ○Eye Glasses ○Hearing Aid ○Hoyer Lift /Sling ○Crutches ○Cane ○TTY
○Walker ○Manual Wheel Chair ○Electric Wheelchair ○Activities of Daily Living Devices ○Plate Guard
○Tray ○ Slip Mat ○Modified Utensils/plate/cup ○ Insulin Pump ○ CPAP/BiPAP ○ Glucometer
○Tracheostomy ○ Respiratory Equipment ○ Other_____

Ambulation and Care

Assistance Needed with Manual Wheelchair:

[ ] No Assistance [ ] Assist on Rough Ground [ ] Assist for Distances [ ] Total Assist [ ] N/A

Assistance with Transferring: Current Weight_____

[ ] No Assistance [ ] Stand and Pivot Transfer [ ] 2 Person Lift *(must be 80 lbs or less)* [ ] Hoyer lift

Other Ambulation Needs: [ ] Some Support on Certain Surfaces [ ] Support for long distances [ ] Support due to vision

Toileting

Do you wear Attends/Briefs/Diapers? ○ Yes ○ No If yes, When? ○All Day ○ Night Only

Bathroom Assistance: ○ Independent ○ Some Assistance ○ Total Assistance **BM Routine/Frequency?**

Assistance with cleaning after BM ○ Yes ○ No

Do you need assistance with the following? ○ Yes ○ No

Camper Utilizes:
[ ] Colostomy Appliance [ ] Digital Stimulation [ ] In-Dwelling Catheter
[ ] Suprapubic Catheter [ ] Ileto Appliances [ ] Urinary Catheter
[ ] Intermittent Catheterization [ ] Urinal

Monitor BM?
○ Yes
○ No

Detail Level of Assistance:

Dressing

Level of Assistance Needed:
○ Independent ○ Some Assistance ○ Total Assistance [ ] Verbal Prompts

Detail Level of Assistance:

Does the camper need assistance in the event of a fire, tornado, flood, or bomb threat? ○Yes ○No

Overnight Supports / Nighttime Routine **(Day camp can skip this section)**

Level of Assistance Needed: ○ Independent ○ Some Assistance ○ Total Assistance

Do you use any of the following: ○ CPAP ○ BiPAP Notes:

Do you sleep through the night consistently? ○Yes ○No If no, explain:_____

The following works best if having difficulty falling asleep:

Communication **(Select option for all)**

Communication Device ○Yes ○No **Device Type?**_____	Braille ○Yes ○No
Visual Impairment ○Yes ○No	Large Font ○Yes ○No
Non Verbal ○Yes ○No	Verbal ○Yes ○No
Other Communication Needs:	ASL ○Yes ○No

Verbal and Physical Aggression (towards self, others or property)

Aggressiveness: ○Not Aggressive ○May Strike or Swear Occasionally ○Regularly Strikes or Swears

Type: [ ] Physical [ ] Verbal [ ] Self-Injurious Behaviors

Please Explain:

Staff Supports:

Client Coping Strategies:

Known Triggers:

Elopement **(Select All that Apply)**

[ ] Stays with the Group [ ] Wanders Away [ ] Actively Leaves Group [ ] Hides [ ] Declines to Participate

Please Explain:

Tips to Redirect:

Transitions

○Transitions Well ○ 5 Minute Warning ○ Visual of Transition ○ Struggles with Transitions

Support Recommendations:

Over-Stimulation
Causes: ○ Large Groups Situations ○ Noises ○ Smells ○Other:_____ ○ N/A
Explain:
Support Recommendations:
History of Sexual Behavior
○No Sexual behavior observed ○Unsolicited sexual comments ○Unsolicited sexual touching ○Masturbation
History of Sexual Abuse
○YES ○NO
Support Recommendations:

*****If at any time the team experiences behaviors that interfere with the health and safety of the camper, team members, or other campers, the Director and Assistance Director will evaluate documentation, current supports of the camper, and the current available team member support. If the Director and Assistance Director determine a new level of support is necessary for the camper, the Director and Assistant Director will inform legal guardian and/or case manager of support changes, frequency of services, and whether or not the program is able to support the current camper's needs. Easterseals will attempt to service and support campers who experience interfering behavior using PBS and accommodations. The safety of all campers and team members will be priority in determining ability to serve campers.

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: _____

Easter Seals Camp Sunnyside

Medication Name including dose of pill (mg/ml/ect.)	Quantity	Times of Administration {AM/PM)	Special Instructions
Example- Tylenol 325mg	2 capsules	*8am, 8pm, and as needed*	*whole in applesauce*
Example- Omeprazole 20mg	1/2 tablet (10mg)	*7:30 am, 4:00 pm*	*crushed through G-tube*
**For any questions regarding medication lists or med changes, please email:* *CampandRespite@easterseals.org ATTN: Nurse in subject line*		** Medications are typically administered at 08:00 am (before Breakfast); 12:00 pm (before Lunch); 5:00 pm (before Dinner); and 8:00 pm (Bedtime). Please list specific times if medication/treatment is otherwise scheduled. **To minimize long check in times, we ask that you ONLY bring the number of pills that are needed for the duration of stay plus ONE extra dose. ** All medications must have presciptions attatched, Over-the-counter pills should be in original packaging. Thank you!	

Physical Examination Form

If a different form is submitted, please be sure that any necessary activity restrictions are submitted by the physician.

Patient Name: _____ Date of Birth: _____Today's Date: _____

Medical History: _____

_____

Surgical History: _____

_____

Height: _____ Weight: _____

Vitals Signs: Temp _____ HR: _____ _BP: _____ RR: _____ Pulse Ox: _____

	Normal	Abnormal Findings
Neuro		
Head/EENT		
Respiratory		
Cardiac		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Integumentary		

Are immunizations up to date? YES ____ NO _____ (*Please attach a copy of all immunization records*)

Is the applicant under the care of a physician for non-preventative care? YES _____ NO _____

I agree that medication will be a part of service provided as needed. Medications have been reviewed by a licensed health professional in the last 12 months YES_____ NO_____

The applicant can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, and other outdoor activities: YES _____ NO _____ If no, please explain: _____

_____

I have examined the above individual and reviewed his/her health history. It is in 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 at this time.

Signature of Licensed Medical Professional:_____ **Exam Date**: _____

Printed Name: _____ Phone Number: _____

Easterseals Rights and Responsibilities Statement Form

Easterseals operates with the goal of assisting individuals to reach a maximum level of independence. Easterseals recognizes that, to achieve this goal, each client should be an active and integral part of the programs and services offered. Considering the philosophy, clients are encouraged to remember and exercise the following rights and responsibilities.

Rights of Easterseals Clients:

1. Clients have the right to be valued and respected as individuals.
2. Clients have the right to be informed and exercise their rights and responsibilities. If a client has a restriction to keep them safe, they have a right to understand why, to have it documented and to have a plan to restore their rights
3. Clients have the right to privacy.
4. Clients have the right, when there is a need, have support to exercise and safeguard their rights.
5. Clients have the right to decide which personal information is shared and with whom and the right to be informed about how those decisions impact funding.
6. Clients have the right to make informed choices about where they work.
7. Clients have the right to make informed choices about how they spend their free time.
8. Clients have the right to make informed choices about where and with whom they live.
9. Clients have the right to choose their daily routine.
10. Clients have the right to be a part of community life and perform varied social roles.
11. Clients have the right to have a social network and varied relationships.
12. Clients have the right to develop and accomplish personal goals.
13. Clients have the right to financial management support which is addressed on an individual basis.
14. Clients have the right to supports to maintain good health.
15. Clients have the right to intimacy which is respected and supported.
16. Clients have the right to have an impact on the services they receive.
17. Clients have the right to be provided with provisions and oversight of the high-quality supports and services.
18. Clients have the right to input into which staff they will work with.
19. Clients have the right to enter contracts.
20. Clients have the right to know the rules that apply to their conduct in the program.
21. Clients have the right to sign or not sign any of the program paperwork such as staffing reports and the personal release form used for publicity purposes. Clients have a right to understand how their decision will impact funding and access to services.
22. Clients have the right to decide who attends their staffing.
23. Clients have the right to review their case file in the presence of a designated Easterseals Iowa team member at a time scheduled with Easterseals Iowa.
24. Clients have the right to referral suggestions upon discharge.
25. Clients have the right to know the benefits to which their entitled.
26. Clients have the right to modified equipment and other techniques as a part of reasonable accommodation.
27. Clients have the right to have freedom from abuse, financial or other exploitation, retaliation, humiliation, and neglect.
28. Clients have a right to have an option of telehealth as permitted and funded by funding source

Responsibilities of Easterseals Clients:

1. Clients have the responsibility of abiding by the rules and regulations of the programs and/or when appropriate the employers.
2. Clients have the responsibility of treating others with the respect and dignity they themselves would expect. This respect also extends to the property of the facility and to the property of other persons.
3. Each client is responsible for their own belongings and property. Easterseals assumes no responsibility for loss.
4. Clients have the responsibility of reimbursing or repairing any property damage caused to another client's property or Easterseals property.
5. Clients have the responsibility of providing to the best of his/her knowledge, accurate, complete, and timely information needed by the program.
6. It is the responsibility of the client or their representative to report any changes of personal data (i.e., name, address, phone, medication, restriction) to Easterseals team members.
7. Clients have the responsibility of letting team members know, to the best of his/her ability, whether he/she comprehends the plans and what is expected of him/her.
8. Clients have the responsibility of following the plans decided upon by the interdisciplinary team to the best of their ability or communicating to the team, to the best of their ability, why they are not following the plans.
9. It's the responsibility of the client to attend any scheduled meetings regarding the continuation of the client's programming. Easterseals can enforce a break in services due to program attendance, incidents in the program or other notable issues. Return to the program will not occur until a meeting has been held.

Rights of Easterseals Guardians:

- Guardians have the right and should ask questions to understand service delivery and process.
- Guardians have the right to communicate concerns with program directors and or their designee.
- Guardians have a right to utilize the Easterseals' Grievance and Appeal Process in the event they are unable to develop a solution with the program director and or their designee.
- Guardians have the right to participate in all meetings and planning that pertains to the client.
- Guardians have the right to review the client's file at Easterseals in the presence of a designated Easterseals team member at schedule time
- Guardians have the right to provide training to team members about working with the client.
- Guardians have the right to be valued and respected by Easterseals team members.
- Guardians have the right to be treated without discrimination by Easterseals team members.
- Guardians have the right to informed consent. Informed consent means that the Guardian understands and agrees with program decisions.
- Guardians have the right to be updated on the client's progress as desired.

Responsibilities of Guardians:

- Guardians will support Easterseals' decision to operate client choice programming; Easterseals believes that each person has preferences, desires and goals and will work with clients to understand and support them in obtaining the quality of life they desire.
- Guardians have the responsibility of treating Easterseals team members with the respect and dignity. This includes refraining from any form of discrimination based on age, sex, race, religion, sexual orientation, gender identity or disability. Swearing, threating, or intimidation of team members will not be tolerated.
- Guardians are expected to follow department communication processes
- Guardians are expected to follow Easterseals Grievance and Appeal Process
- Guardians will support Easterseals decisions made in relation to the State laws and accreditation requirements in which the agency operates.
- Guardians have the responsibility to report any changes of the client's personal data.

NONDISCRIMINATION

No person shall be discriminated against because of race, color, national origin, sex, sexual orientation, gender identity age, mental or physical disability, creed, religion, or political belief when applying for or receiving benefits or services from Easterseals. No person will be retaliated against or have barriers to services after filing complaints or concerns.

Confidentiality: According to federal and state law, any information given to any member of our team members is considered to be privileged and cannot be revealed to family, friends, courts, spouse, attorneys, probation officers, or employers without your written consent or the written consent of your legal representative unless you are court ordered for treatment or evaluation. Easterseals does cooperate with law officials with regards to subpoenas etc.

There are six exceptions regarding full confidentiality in Easterseals programs:

A. **Reporting dependent adult abuse:** All Easterseals team members are mandatory reporters. It is the policy of Easterseals team members to report to the Department of Human Services (DHS) if abuse to dependent adults is suspected.
B. **Reporting child abuse:** All Easterseals team members are mandatory reporters. It is the policy of Easterseals team members to report to the Department of Human Services (DHS) if child abuse is suspected. To report suspected incidents of abuse, neglect, exploitation or unexplained death for a minor child or dependent adult, contact the Department of Human Services 24 hours a day, 7 days a week at 1-800-362-2178.
C. **Dangerous to self and others**: When a client indicates that he or she is a danger to self or others, Easterseals team members shall act in a manner which is most beneficial in assuring the safety of the client and others.
D. **Minors:** The holder of confidential information is the parent(s) or legal guardian(s).
E. **Individuals with Chronic Mental Illness**: Section 228.8 of the Iowa Code specifies circumstances which allow disclosure of limited mental health information to family members who are directly involved in the care of an individual with chronic mental illness or monitoring the treatment of the individual. The family member must make a written request for the information unless an emergency exists. Information which may be released is limited to diagnosis, prognosis, medication, and compliance (not to exceed six months), and treatment plan. If we release such information, you will be informed of the disclosure.
F. **Quality of Service:** Easterseals waiver programs are accredited by the Home and Community Based Waiver. All other programs are accredited by CARF. Our services are subcontracted through Polk County Behavioral Health Region (PCBHR), or a State Manage Care Organization (MCO) who monitor our funding and quality of service provision.

I acknowledge that I have been informed and received a copy of these rights and responsibilities.

I have been offered a copy of Easterseals' client handbook. _____Accepted _____ Declined
N/A for AIM, Brain Health, Camp/Respite, Crisis Stabilization, Rural Solutions or Assistive Technology.

_____ _____
Client Signature & date Legal Guardian & date

_____
Legal Co-Guardian & date

_____
Easterseals Team Member Signature & date

-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

Client Name:_____ Program Name:_____

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

Consent to Leave Phone Messages/Release of Information

Client Name:_____ Program Name:_____

By completing the consent below, you authorize us to release information or leave a detailed message on voicemail or with a specific individual. All campers must have an emergency contact listed who will answer their phone and respond to messages while the camper is at camp.

Option A- I give my consent to Easterseals to release and/or leave messages regarding services as necessary in the following situations:

- ☐ 1. On cell phone via voicemail
- ☐ 2. On cell phone via text message
- ☐ 3. On answering machine at home
- ☐ 4. On voicemail at work
- 5. With _____ (Relationship) _____

_____ _____

Client Signature Date

_____ _____

Guardian Signature (if applicable) Date

Option B- ☐ I do not consent to messages being left. Please contact directly

_____ _____

Client Signature Date

_____ _____

Guardian Signature (if applicable) Date