Easter Seals Oregon – Rogue Valley
Participant Eligibility Policy

The *Easter Seals Oregon Rogue Valley Area Programs (Saturday R&R, Summer Day Camp, Interagency Socials and Inclusion Services)* are dedicated to providing recreation/social programs for children with disabilities/special needs, ages 3-21, as well as providing respite to family members.

Criteria for Participation

1. The applicant eligible for Easter Seals programs is any person 3 to 21 years of age who has a disability/special need and meets the eligibility requirements. Eligibility for program admission is also based upon the likely benefits of the R&R, Day Camp, Social or Inclusion experience and expectation of capability of program participation.

2. ESO program applicants must meet the following eligibility guidelines:

    a. The applicant should be capable of responding to ESO staff and volunteers with either a verbal, audible or physical response. This response could be an eye shift or a very slight gesture.
    b. The applicant must be able to adapt to the ESO program setting without detracting from the group. This includes, but is not limited to, following direction of staff and volunteers, and participating in activities to the best of his/her abilities.
    c. The applicant must not be abusive toward himself/herself or others.
    d. The applicant must be free of certain medical conditions in which the program environment might not be appropriate or in the best interest of his/her medical rehabilitation. The Rogue Valley Area Director will review all applications and medical forms in question to determine eligibility.
    e. A conditional acceptance may be made for new applicants for their first year of attendance.

Please call our office with any questions. Every person is unique and will be considered for enrollment.

3. Applicants who ***do not*** meet the ESO programs eligibility guidelines:

    a. Applicants with a medical condition that requires specialized medical treatment (i.e., intravenous infusions).
    b. Applicants with a medical condition associated with a high risk for complication or injury (i.e., extreme respiratory problems, the recovery period following a recent surgery or injury, or a history of orthopedic complications).
    c. Applicants physically abusive toward self or others, including: hitting, biting, scratching, spitting, kicking, etc.
    d. Applicants verbally abusive causing disruption of the program.
    e. Applicants with conditions/behavior problems causing disruption to the program.
    f. Applicants with inappropriate sexual behavior.
    g. Applicants under “Do Not Resuscitate” orders.

4. Applicants will not be admitted to ESO programs if their health in any way endangers other participants, staff or volunteers or if there is a problem requiring the attention of a physician. Such conditions could be defined as, but are not limited to the following:

    a. Temperature greater than 100.4° orally.
    b. Blood pressure greater than 160/90.
    c. Heart rates greater than 120 BPM.
    d. An open, draining rash/wound.
    e. Topical parasites (i.e., lice, scabies, etc.)
    f. Vomiting or Diarrhea within the past 24 hours.

5. Applicants may exhibit behaviors/conditions following their arrival that would necessitate deferral of participation. Among these behaviors/conditions, but not exclusive, are:

    a. Any behavior/condition outlined previously in sections three (3) and four (4) of this policy.
    b. Exacerbation of medical condition and/or signs of infection or communicable disease.
    c. Inability or refusal of participant to eat or drink amounts adequate for nutritional support.
    d. Inability or refusal of participant to take personal prescription medication.

6. Easter Seals Oregon reserves the right to accept or deny applications on site or prior to attendance and will be the party responsible for acceptance or denial.

1/08 KS

EASTER SEALS OREGON
ROGUE VALLEY SERVICES
Participant Application Form

Easter Seals Oregon
406 S Riverside Ave Ste 101
Medford OR 97501
(541) 842-2199 (Phone) 842-4048 (Fax)

APPLICANT INFORMATION ***DATE:***

CHILD'S NAME:	AGE:	D.O.B.:	WEIGHT:
SIBLINGS: NAME:	D.O.B.: AGE:	ALLERGIES:	
NAME:	D.O.B.: AGE:	ALLERGIES:	
NAME:	D.O.B.: AGE:	ALLERGIES:	
PARENT'S NAME:	**EMAIL:**		
ADDRESS:		ZIP:	
PHONE (HOME):	(CELL):		

EMERGENCY INFORMATION

PRIMARY EMERGENCY CONTACT PERSON'S NAME:		
ADDRESS:		ZIP:
PHONE (HOME):	(CELL):	
LIST TWO PERSONS TO CONTACT IN CASE OF EMERGENCY:		
(1) NAME:	RELATIONSHIP:	PHONE:
(2) NAME:	RELATIONSHIP:	PHONE:
PARENTS: WHEN CHECKING YOUR CHILDREN IN, PLEASE LEAVE A PHONE NUMBER WHERE YOU CAN BE REACHED DURING PROGRAM HOURS.		
PEDIATRICIAN'S NAME:		
OFFICE ADDRESS:	ZIP:	
PHONE:	DATE OF LAST VISIT:	

HEALTH INFORMATION

PRIMARY DISABLING CONDITION:
PARTS OF BODY AFFECTED:
SECONDARY DISABLING CONDITION:
DOES YOUR CHILD HAVE SEIZURES? [ ] YES [ ] NO CONTROLLED? [ ] YES [ ] NO PLEASE EXPLAIN OR DESCRIBE:
DOES YOUR CHILD HAVE ALLERGIES? [ ] YES [ ] NO DESCRIBE:
DOES YOUR CHILD USE A WHEELCHAIR? WALKER? CRUTCHES? BRACES? OTHER? (Please circle and describe):

MEDICATIONS – List all medications and non-prescription drugs that our staff will be dispensing <u>during program hours</u>:

Medication	**Purpose**	**Potential Reactions**

IMPORTANT: The medications/non-prescription drugs must be left in the bottle/package with the prescription information, or the staff will be unable to dispense it. <u>This is the law!!</u>

TOILETING

DESCRIBE YOUR CHILD'S TOILETING HABITS (Please describe fully, so that we may make your child's stay with us as easy as possible.) IS YOUR CHILD INDEPENDENT IN TOILETING? [ ] YES [ ] NO DOES YOUR CHILD NEED TO BE REMINDED? [ ] YES [ ] NO DOES YOUR CHILD USE A DIAPER? [ ] YES [ ] NO **(PLEASE BRING EXTRA DIAPERS AND SET OF CLOTHES)** HOW OFTEN DOES IT NEED TO BE CHANGED? _____
DOES YOUR CHILD USE ANY OTHER BOWEL/BLADDER SYSTEM?
HOW MUCH ASSISTANCE DOES YOUR CHILD NEED IN THE BATHROOM?
OTHER INFORMATION ABOUT TOILETING HABITS?

EATING SKILLS

LIST FOOD OR FLUIDS YOUR CHILD CANNOT HAVE DUE TO ALLERGIES OR REACTIONS:
PLEASE DESCRIBE YOUR CHILD'S EATING SKILLS (Describe fully. Does your child eat independently, need total assistance, use utensils, use a glass, use any adaptive equipment?):
DOES YOUR CHILD HAVE ANY FEEDING OR SWALLOWING DISORDERS?
DOES YOUR CHILD REQUIRE A SPECIAL SNACK? [ ] YES [ ] NO (IF YES, WE ASK THAT YOU PROVIDE IT.)

ADDITIONAL INFORMATION

WHAT ARE YOUR CHILD'S FAVORITE ACTIVITIES? (Please describe fully, so that we may make your child's stay with us as enjoyable as possible.)

WHAT IS YOUR CHILD'S FORM OF COMMUNICATION?

WHAT SERVICES DOES YOUR CHILD CURRENTLY RECEIVE?

CURRENT SCHOOL _____ GRADE LEVEL _____

IS CHILD ON AN IFSP/IEP? _____ YES _____ NO

BEHAVIOR INFORMATION

IS YOUR CHILD…

SELF-ABUSIVE _____ YES _____ NO ABUSIVE TO OTHERS _____ YES _____ NO
VERBALLY ABUSIVE _____ YES _____ NO PHYSICALLY ABUSIVE _____ YES _____ NO

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE CONTACT THE R&R COORDINATOR TO DETERMINE ELIGIBILITY FOR THE PROGRAM.

DESCRIBE YOUR CHILD'S BEHAVIOR PATTERNS, I.E., AFFECTIONATE, LIKES BACK RUBS, TANTRUMS, BITES, ETC.

ARE YOU CURRENTLY WORKING ON A BEHAVIOR MANAGEMENT PROGRAM? _____ YES _____ NO

DESCRIBE BEHAVIOR MANAGEMENT TECHNIQUES YOU WOULD LIKE US TO FOLLOW? (If other than time out and positive redirection, please talk with coordinator)

SWIMMING (SUMMER DAY CAMP ONLY)

WOULD YOU LIKE YOUR CHILD TO PARTICIPATE IN THE SWIMMING/WATERSLIDE PROGRAM AT *JACKSON* ***POOL***?
[ ] YES [ ] NO IF YES:

•DOES YOUR CHILD REQUIRE ASSISTANCE WITH DRESSING? [ ] YES [ ] NO
•DOES YOUR CHILD REQUIRE 1:1 ASSISTANCE IN WATER? [ ] YES [ ] NO

(***Easter Seals*** will make every effort to have a volunteer available to assist your child in the water if they need 1:1 assistance. If this is not possible, we will contact you in advance. For those planning to swim, please bring a suit and towel for each child.)

PLEASE LIST ANY OTHER INFORMATION THAT WE MAY NEED TO KNOW WHILE THEY ARE IN THE POOL/DRESSING ROOMS.

EASTER SEALS OREGON
ROGUE VALLEY SERVICES

Parent Agreement Form

Please read each paragraph and initial your approval.

GUARDIAN CONSENT FORM

RELEASE AND WAIVER: In the consideration of the permission granted by Easter Seals Oregon for _____ _____ (Participant) to participate in activities at Easter Seals Oregon, the undersigned hereby agrees to release and hold harmless Easter Seals Oregon, its officers, agents and employees from all claims, demands, actions or cause of action, which the participant, his/her personal representatives, heir and next of kin, may or might have against Easter Seals Oregon, its officers, agents and employees on account of injury to or death of the participant, or damage to the property of the participant arising out of the participant's participation in activities at Recreation & Respite Programs, Inclusion Efforts and any Rogue Valley Services, that are not due to the negligence of the Easter Seals Oregon. The undersigned further agrees to indemnify and hold harmless Easter Seals Oregon from any loss, liability, damage or costs that might have incurred due to the acts of the participant during the participation in activities at Recreation & Respite Programs, Integration Efforts and any Rogue Valley Services. _____ Initial

MEDICAL RELEASE: In the case of injury or illness, appropriate staff will attempt to contact the legal guardian, and/or listed "contact person," of _____ (Participant). If participant is own legal guardian, staff will attempt to contact listed "emergency contact person." I hereby give my consent to the Rogue Valley Director or Program Coordinator of the Rogue Valley Service or the staff member in charge at the time, to take direct emergency action when, in his/her opinion, such action is deemed prudent or necessary. If there exists a need for emergency transportation, the legal guardian is responsible to pay for the costs. Medical care shall include, but not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, hospital services and other procedures, etc. If the above listed contacts are not reasonably assessable, taking into account all of the circumstances, the attending physician or nurse will take whatever action deemed necessary. This agreed upon covenant will enable all emergency treatment necessary for the best interest of the life and health of the above said participant. Easter Seals Oregon staff member in charge has the right to refuse acceptance of a child who shows symptoms of a contagious illness (i.e., cold and flu) at the time of the program. _____ Initial

The Rogue Valley Services will not honor "Do Not Resuscitate" physicians' orders. _____ Initial

PHOTOGRAPHIC RELEASE: **Participant Name: _____**

I hereby consent to any photographic material taken in connection with his/her participation at any Rogue Valley Services. I authorize Easter Seals Oregon and National Easter Seals, to use and distribute for publication, as they see fit, these photographs for clinical, education, scientific, or public relations purposes. It is clearly understood that no royalty, fee or other compensation of any character shall become payable to me by reason of such use or release. **θ Yes θ No**

I DO HEREBY ACKNOWLEDGE THAT I HAVE CAREFULLY READ ALL OF THE FOREGOING AND THAT I UNDERSTAND AND AGREE TO ITS CONTENTS. I THEREFORE, MAKE THIS AGREEMENT AND SIGN THIS STATEMENT ON MY OWN BEHALF AND/OR ON BEHALF OF MY CHILD FOR WHOM I AM THE LEGAL GUARDIAN. THIS FORM MUST BE SIGNED BEFORE THE PARTICIPANT CAN ATTEND EASTER SEALS PROGRAMS AND SERVICES. THERE WILL BE NO EXCEPTIONS!

_____

Client/Parent or Legal Guardian Date

THE AGREEMENT MUST BE SIGNED BEFORE PARTICIPATING IN OUR SERVICES. NO EXCEPTIONS WILL BE ALLOWED. THANK YOU!

Office Use Only:

Date Application Received: _____Receiving Fee Assistance? _____

EASTER SEALS OREGON

- Rogue Valley Services -

Medical Form

Easter Seals Oregon
406 S Riverside Ave Ste 101
Medford OR 97501
(541) 842-2199 (Phone) **842-4048 (Fax)**

To be completed by the applicant child's physician. Medical form is ***required*** for participation in all Easter Seals Oregon Rogue Valley Services.

Child's Name:	Birth Date:
Parent's Name:	Age:
Primary Diagnosis:	
Secondary Diagnosis:	
Specific precautions that should be taken:	
Medications:	
Precautions:	

Please make note of any other information, as you feel necessary. (For example, any of the following medical conditions that apply to your patient: coronary risk/disease, respiratory difficulties, diabetes, hemophilia, etc.)

_____

_____

_____

Date of most recent examination _____

Can this child participate in a swimming/waterslide program at Jackson pool?

θ Yes θ No

_____

Physician's signature Date

Please print: _____
Physician's Name

_____
Address

_____
City/State/Zip

_____
Phone