Easterseals Iowa

Sunny Days 2021 Checklist

*****Please allow up to 2 weeks of processing of application once ALL paperwork from checklist below has been received to the Program and Support Specialist. Please send all items together, in one shipment, in order to begin the process of the application. Sending partial applications does not hold or reserve a spot for your client. *****

Ages 6 -12. Program is Monday—Friday, 8 am until 5 pm. The program is a 1:5 staff to client ratio. This program can be paid for with Waiver Services or Private Pay. Private Pay Cost: $210 per week. Waiver Code is T2037 at 180 units per week.

As you complete the application, please check off the items from this list:

- ☐ 2021 Application *(Signature on last page)*
- ☐ All Release Forms *(Waiver of Liability, Photo Consent Form, Notice of Privacy Practices)*
- ☐ Health History
- ☐ Physical Form *(valid for 2 years)* + immunization records (*Signature required—we do not accept electronic signature)*
- ☐ Current Individual Care Plan (ICP)/Consumer Comprehensive Service Plan (CCSP) and Release of Information *(Valid for 1 year, Please contact your case manager)*
- ☐ Financial Information Form
- ☐ Registration Form
- ☐ $50 non-refundable deposit or authorized Waiver Funding (Waiver clients only—please contact your Case Manager) ***Please do NOT send deposit separately.***

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

Once we have registered you for session(s), you will receive a letter via email confirming the weekend(s) you are registered for. 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!

Office use only:

-Sunny Days Application 2021-

Are you privately paying? ◯ **YES** ◯ **NO**
If so, please attach $50 deposit.

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:
Email:		Birthdate: / /

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

Preferred Language:

Marital Status: ◯ Single ◯ Married/Cohabitating ◯ Separated ◯ Divorced ◯ Widowed

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 ◯ N/A ◯ Veteran

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

Client: Income / Employment (If Applicable)	
Monthly Income:	Source: ◯ Community Employment ◯ Other ◯ SSDI ◯ SSI
Notes:	

Employments ☐ Is Current?		
Employer:	Position:	
Employer Contact Info		
Address:		
City/State:	County:	Zip Code:
Supervisor:	Phones:	Regular Hours:
Wage:	Start Date:	End Date:

Guardian Information

First Name:	Last Name:	Relationships:
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

Managed Care Policy Number:

Case Manager:	Phone:	Fax:
Agency:	Email:	
Address:	City/State:	Zip Code:
Regular Physician:		
Address:	City/State:	Zip Code:
Daytime Phone:	Fax Number:	
Client Height:	Client Weight:	

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)

Mental Disorders ☐	*Cerebral Palsy* ☐	*Scoliosis* ☐
Autism ☐	*Epilepsy* ☐	*Spina Bifida* ☐
Down's Syndrome ☐	*Arthritis* ☐	*Spinal Cord Injury* ☐
Other Psychological Disorders ☐	*Asthma* ☐	*Head Injury* ☐
ADD/ADHD ☐	*COPD* ☐	*Speech, Language & Voice Dysfunction* ☐
Developmental Delays ☐	*Diseases of the skin & tissue* ☐	
Intellectual Disability ☐	*Shunts* ☐	

Secondary:

Other:

Allergies

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

Dietary Information

(Please mark all that apply)

Are you on a special diet? ◯ YES ◯ NO

- ☐ G-Tube If so, are you NPO? ◯ Yes ◯ No
- ☐ Mechanical Soft
- ☐ Pureed
- ☐ Fluid Restriction required per Physician
- ☐ Other _____

Are you Diabetic? ◯ Yes ◯ No

- ☐ Medication Controlled
- ☐ Diet Controlled
- ☐ Carb Count
- ☐ Insulin Controlled

Eating: ◯ Eats Independently ◯ Total Assistance

- ☐ Monitor Portions
- ☐ Help Cutting Up Food

Notes:

Assistive Technology

(Select all that apply - underlined items are supplied by ESI**)**

☐ AFO/KAFO ☐ Aug/Alt Communication Device ☐ **Bed Rails** ☐ Eye Glasses ☐ Hearing Aid ☐ TTY ☐ **Shower Chair**
☐ Other Bathing Aid ☐ Gait Belt ☐ **Grab Bars** ☐ **Hospital Bed** ☐ Hoyer Lift /Sling ☐ Crutches ☐ Cane
☐ Walker ☐ Manual Wheel Chair ☐ Electric Wheelchair ☐ Activities of Daily Living Devices ☐ Plate Guard
☐ Modified Utensils ☐ Tray ☐ Slip Mat ☐ Specialized Cup ☐ Specialized Plate ☐ 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)*

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

Personal Hygiene **(Brushing teeth, shower etc.)**

Level of Assistance Needed: ◯ Independent ◯ Some Assistance ◯ Total Assistance ☐ Verbal Prompt

Detail of level of Assistance:

Toileting

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

Bathroom Assistance:
◯ Independent ◯ Some Assistance ◯ Total Assistance ◯ Assistance with cleaning after BM

Monitor BM?
◯ Yes
◯ No

Uses the following:

- ☐ Colostomy Appliance
- ☐ Digital Stimulation
- ☐ In-Dwelling Catheter
- ☐ Suprapubic Catheter
- ☐ Ileto Appliances
- ☐ Urinary Catheter
- ☐ Intermittent Catheterization
- ☐ Urinal
- ☐ Other

Do you need assistance with the above? ◯ Yes ◯ No

Detail Level of Assistance:

Dressing

Level of Assistance Needed:

◯ Independent ◯ Some Assistance ◯ Total Assistance ☐ Verbal Prompts

Detail Level of Assistance:

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

Communication

Communication Device ◯ Yes ◯ No	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:_____

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:

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 client is their own guardian client 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.

_____ _____

Client 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

-Health History Form-

Client Name: _____ Birthdate: _____

please complete all fields and return this form

In the event of an emergency, I give permission for Easterseals Iowa to contact the following ***three*** individuals: (Please list contacts in the order you would like them to be contacted). In the event of an early discharge please have a plan in place within an hour.

Name:_____ Relationship:_____

Work Phone: _____Home Phone: _____Cell Phone: _____

Name:_____ Relationship:_____

Work Phone: _____Home Phone:_____Cell Phone:_____

Name:_____ Relationship:_____

Work Phone: _____Home Phone:_____Cell Phone:_____

Regular Physician: _____ Daytime Phone: _____

Preferred Hospital: _____ Medicaid ID: _____

Insurance Carrier: _____ Policy #: _____

Please List all allergies and reactions:_____

_____

Do you carry an Epi Pen? ◯Yes ◯No ****If so, please bring your Epi Pen with you to your sessions****

Any recent surgery or illness?_____

Any Chronic or recurring illness?_____

Any other information?_____

Does this person have a seizure disorder? ◯Yes ◯No Date of last Seizure:_____

Scheduled, PRN (as needed) and Non-Prescription Medications: Dosage:

_____ _____

_____ _____

_____ _____

Name of Person Completing Form:_____

Date:_____ **Contact Number:** _____

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:**_____

-2021 Financial Form-

Client Name: _____ **Birthdate:**_____

Do you live in a group home? ◯ **Yes** ◯ **No**

Are you privately paying? ◯ Yes ◯ No

If yes, please fill out this section only

Where would you like us to send the invoice?

Name:_____ Phone:_____

Address:_____ City, State, Zip:_____

☐ I prefer electronic billing statements Email Address for billing:_____

Method of Payment:

◯ **Check** *(Make payable to Easterseals Iowa)*

Amount Enclosed: $_____

◯ **Credit Card** ◯ Visa ◯ MasterCard ◯ Discover

Amount Authorized: $_____

Card Number:_____

Expiration Date:_____ 3 Digit Code: _____

Name on Card: _____

Signature:_____

$50 Deposit Required

Would you like us to charge your card for the remaining balance the Wednesday before the session? ◯ Yes ◯ No

Please note:

- The non-refundable $50 deposit must be sent with the application. **Please do not send the deposit separately**. It will be applied to the first session.
- Any application turned in **after July 1st will require the payment to be made in full** before the client can be registered.

Are you paying with a waiver? ◯ Yes ◯ No

If yes, please fill out this section only

Managed Care Organization (MCO):

◯ Iowa Total Care

◯ Amerigroup Iowa

◯ HIPP/IME

MCO ID Number:_____

Medicaid ID Number:_____

Please contact your case manager before sending in the Application and Registration forms to ensure the proper funding is in place. A current care plan, provided by your case manager, is required by registration. Sunny Days waiver code T2037 at $1.11 a unit, 180 units total per week.

Case Manager Name:_____

Case Manager Phone Number:_____

Case Manager Email:_____

Important!

If you are **Privately Paying:**

- A non-refundable $50 deposit is required to register a client. The client cannot be registered until we have received this and we do not reserve or hold spots. The $50 will be applied to the first session. Please send the deposit with the application to our Program and Support Specialist at:

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

- **Full payment is due three weeks before the client attends his/her session.** Failure to pay in advance may result in a loss of registration for that session. If the remaining balance is sent separately from the deposit and application, please send it to our Accounting Department at:

  Easterseals Iowa
  Attn: Accounting
  401 NE 66th Ave
  Des Moines, IA 50313

- The entire amount is required to be paid even if the client will not attend the entire session.

- Any application turned in after July 1st, 2021 will require the session payment to be made in full before the client can be registered.

- If the client can no longer attend the registered sessions, please contact the Program and Support Specialist at 515-309-2375. Failure to cancel the session at least one week before the session begins may result in the billing contact identified on the Financial Form being charged for the Full session.
- Failure to cancel registration could lead to cancellation of future registered weeks.
- Please remember the Summer Programs will maintain a strict adherence to the 5:00 pm closure time. There will be a late charge of $10 due at the time of pick-up if a parent comes for a client between 5:00 pm – 5:10 pm. After 5:10 pm, there is an additional charge of $1 per minute.

Important!

If you are using **Waiver Funding:**

- **Please contact your case manager before sending in the application.** We ask that you discuss with them how many sessions you are interested in, what type(s), and what dates the sessions occur on to ensure the proper funding is in place.
- **A client cannot be registered without the correct waiver funding in place** and we cannot register outside of what the funding authorizes. We also do not reserve or hold spots.
- Please send all funding and billing information with the application to our Program and Support Specialist:

  Easterseals Iowa

  Attn: Camp and Respite

  401 NE 66th Ave

  Des Moines, IA 50313

- Please also have the case manager send the client's Individual Care Plan/Consumer Comprehensive Service Plan (ICP/CCSP) with the application. This document is also required for registration.
- The entire unit amount per session is required to be authorized by the waiver, even if the client will not attend the entire session.
- Below are our waiver rates:

Sunny Days: T2037

$1.11/unit

180 units a week

Please Note:

- The CMH waiver (Children's Mental Health Waiver) can only be used on our weekend respite sessions.
- All other waivers (such as the Intellectual Disabilities Waiver, the Ill and Handicapped Waiver, and the Brain Injury Waiver) are eligible for both weekend respite sessions, Sunny Days, and Super Weekend Respite.
- As we transition to new Managed Care Organizations, we may need to make some adjustments to the registration process. We will communicate those updates as more information becomes available.

- Sunny Days -

Registration 2021

Private Pay Cost: $210 per week Waiver Rate: $1.11 per unit, 180 units per week

Client Name: _____ Today's Date:_____

Medicaid:_____ Date of Birth:_____

Guardian Name:_____ Guardian Email:_____

Guardian Home Number:_____ Guardian Cell Number:_____

Check in is Monday—Friday 8 am until 5 pm. All applications are completed in the order received so please allow two weeks to process. **If your client has never attended Easterseals before, an Intake Process will need to occur before you will be registered and may result in a delay in processing your application. If your client needs 1:1 assistance, please go to www.easterseals.com/ia/camp for more information regarding the registration process.**

Client Age:_____

(When attending)

Please mark only the session(s) you want to be registered

Week 1: June 14-18	Ages 6-12	☐ SD1 Animal Planet
Week 2: June 21-25	Ages 6-12	☐ SD2 Western Week
Week 3: June 28-July 2	Ages 6-12	☐ SD3 Stars and Stripes
Week 4: **July 6-9** (Closed Mon)	Ages 6-12	☐ SD4 Rock and Roll
Week 5: July 12-16	Ages 6-12	☐ SD5 Under the Sea
Week 6: July 19-23	Ages 6-12	☐ SD6 Mad Science
Week 7: July 26-30	Ages 6-12	☐ SD7 Superheroes
Week 8: Aug 2-6	Ages 6-12	☐ SD8 Challenge Week
Week 9: Aug 9-13	Ages 6-12	☐ SD9 Disney
Week 10: Aug 16-20	Ages 6-12	☐ SD10 Nature Unleashed

If you need to cancel a week or make changes please contact the Program and Support Specialist at least a week in advance. Failure to notify the Program Support Specialist of your cancellation could mean cancellation of future registrations.

2021 Sunny Days Themes

SD1 Animal Planet—Join us for some zoo-tastic fun exploring the amazing animal kingdom. We will watch animals in their natural habitat via livestreams, search the nature trail for evidence of local creatures, and we may even get a visit from some furry friends! Wear your cheetah print and zebra striped clothing!

SD2 Western Week —Yeehaw! It's back again for another time around the barrel! Enjoy a rodeo, horseback riding, and lots of Country Western Music during this honky-tonk week. We will also turn ESI into the Wild West with demonstrations from the Pony Express Riders of Iowa. Costumes and Western wear are encouraged!

SD3 Stars and Stripes—Celebrate our great Nation this week with our Fourth of July celebration! This week will be filled with many fun, patriotic activities – including a Parade! Come wearing your red, white, and blue.

SD4 Rock and Roll—If you like to rock and roll, this session is for you! With music blaring all week long on the patio and a live performance by a cover band, this week totally ROCKS! We also encourage our client' creativity by making music and instruments of our own.

SD5 Under the Sea —Mermaids, Sharks, and Sea Creatures OH MY! This week is all about fun filled water activities! Get ready to spend countless hours at Lake Cheerio, search for the Lochness monster, and get wet and wild as we go on an adventure under the sea.

SD6 Mad Science—Whaahaahaahaa! Do you like science experiments? Do you like exploding things? How about rocket ships, and bubbles, and mixing ingredients? Then this week is for you! Come and take part in science experiments and activities, explode watermelons and make magnetic slime!

SD7 Superheroes—This week you will get to experience being a crime-fighting superhero in this fun filled week so bring your superhero costumes. You will get to design your own superheroes logos, draw comics, do the hulk smash and so much more!

SD8 Challenge Week—This week is all about overcoming obstacles and trying new things. Can your cabin succeed? Color Wars, Olympics, Team Initiatives, Capture the Flag, and many more activities will challenge you to push past your limits and achieve greatness.

SD9 Disney—This week you will get to enjoy the magic of Disney while at the Happiest Place on Earth. You will get to eat lunch with Mickey, make your own flubber, have a Lion King karaoke, play Captain Hook toss, pin the carrot on Olaf, and use your fairy dust to make magic happen.

SD10 Nature Unleashed—This Do you like outdoors? Come learn about the wilderness, wildlife, shelter building, and cooking food over a campfire. This week is dedicated to all thing nature! Come join us and embrace the elements as we learn about nature, wildlife, and survival techniques.

Consent to Leave Phone Messages/Release of Information

By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual.

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

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

Client Signature Date

Guardian Signature (if applicable) Date