

Camper Name _____ **EASTERSEALS 2019/2020 ADULT HEALTH INFORMATION FORM AND WAIVER**

Nature of Disability. Please check all that apply

- | | | | | | |
|---|---|---|---|--|-----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Attention Deficit Disorder/ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Behavior Disorder | <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> Disorder |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Developmental Disorder | <input type="checkbox"/> Down Syndrome | |
| <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Fragile X | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Heart, Circulatory, Respiratory Defect | <input type="checkbox"/> Spina Bifida | |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Speech Language/Voice Dysfunction | <input type="checkbox"/> TBI | <input type="checkbox"/> Social/Psychological | | |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Spinal Cord Injury | | <input type="checkbox"/> Visual impairment | <input type="checkbox"/> Partial | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> Quadraplegic <input type="checkbox"/> Paraplegic | <input type="checkbox"/> Other | <input type="checkbox"/> Other | _____ | |

Physician's Name: _____

Physician's Office Phone Number: _____

Dentist's Name: _____

Dentist's Office Phone Number: _____

Health Insurance Company: _____ Name Insured: _____ Policy Number: _____

Health History

Date of the Last Health Exam _____

Has your camper ever experienced any of the following health events? Please check all that apply.
(In the "Date" space, please provide the date of last occurrence when answering yes to each health event)

- | | | | | | |
|-------------------------|---|-------------------|---|-------------------|---|
| Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Behavior Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Hay Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Clotting Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | ADD/ADHD | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Poison Ivy Allergy | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Seizures* | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Speech Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Insect Sting Allergy | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Bedwetting | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Hearing Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Ear Infections | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Fears/Phobias | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Vision Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Headaches | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Sleepwalking | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Hepatitis A | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Frequent Sore Throats | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Head Lice | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Hepatitis B | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ |
| Mononucleosis | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Chicken Pox | <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ | Other | _____ Date _____ |

Summarize camper's medical history/operations/serious Injuries _____

Type of Seizures: _____ Frequency: _____

Describe any warning signs(aura) before seizures. _____

Does the camper have a shunt? Yes No If yes, list special instructions/limitation. _____

Does the camper menstruate? Yes No If yes, is there any special treatment for cramps? _____

Has the camper ever required any psychiatric treatment/counseling or hospitalizations? Yes No

If yes, please summarize (including dates). _____

Medical Exam Summary-The Physician's Medical Examination Summary must be received by Easterseals Tennessee Camp 30 days prior to the first day the seasonal weekend/camp camper will be attending. Missing this deadline will result in the camper's reservation being voided and filled by another camper.

Medication- In an effort to better serve our campers we require all campers to bring pre-packaged medications. This means all medications; vitamins and supplements brought to camp are prepared in a multi-dose blister pack or daily medicine cassette for the duration of their stay. It is preferred that this is done in a "blister pack" by a pharmacist.

CAMPER NAME _____

EASTERSEALS

ADULT HEALTH WAIVER

2019/2020

The following section must be signed by the adult camper/applicant/legal guardian of the adult camper before the application can be processed:

(1) **Approval, Waiver and Activity Consent** - This application has my approval. While Easterseals Tennessee and YMCA Camp Widjiwagan will take every reasonable precaution, it is agreed that Easterseals Tennessee and YMCA Camp Widjiwagan are not legally responsible for any accidents, incidents or injuries that may occur during the camp session, assumes no responsibility for applicant's personal property and are released from liability for any accident, incident or injury except as may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted by myself or physician.

(2) **Medical Treatment** - The undersigned hereby authorizes and grants permission to any licensed/certified medical professional designated by Easterseals Tennessee and YMCA Camp Widjiwagan to provide routine medical care and administer medications or to perform any emergency procedures on the camper that would be jeopardized by any delay in providing such treatment or performing such procedures.

(3) **Media Release** - I, the undersigned, in partial recognition of services rendered and benefits conferred by Easterseals Tennessee and YMCA Camp Widjiwagan, its employees, agents and assigns, to release any pictures, or photographs taken of the above-named client for publication for purposes of conveying information concerning the named individual and/or Easterseals Tennessee or YMCA Camp Widjiwagan. The undersigned hereby agrees to hold Easterseals Tennessee and YMCA Camp Widjiwagan harmless of liability should such pictures or photographs, either accompanied or unaccompanied by printed material, appear in other publication by whomsoever published, circulated or distributed.

I understand that this authorization for media release is subject to revocation at any time, except to the extent that the media has been utilized.

I also understand and agree that this release will terminate only upon the execution of my written statement on another sheet of paper indicating my intent to revoke this authorization.

I ATTEST THAT ALL INFORMATION PROVIDED IN THESE APPLICATION MATERIALS INCLUDING THE APPLICATION, MEDICAL EXAMINATION SUMMARY AND ANY SUPPLEMENTAL ITEMS ATTACHED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Legal Guardian/Adult Camper (signature) _____

Date: _____

Print Name: _____