BRAIN INJURY ASSOCIATION OF ILLINOIS

P.O. Box 64420 ♦ Chicago, Illinois 60664-0420

312.726.5699 ♦ 800.699.6443 ♦ 312.630.4011 *fax*

e-mail: info@biail.org www.biail.org

CAMP FUNZONE at Red Leaf

BIA at Camp Red Leaf
26710 W Nippersink Rd
Ingleside IL 60041

TO: Camp FunZone Campers and Families

Enclosed please find the Camp FunZone Camp Application, and a camp information sheet. Upon receipt of your completed application and payment, additional information will be sent to you following the camp application review.

IMPORTANT: Make an appointment with your doctor as soon as possible! Please be mindful of the required date for the TB test. Remember, the **deadline for camp registration is April 15, 2017**. The signed medical portion of the application can be sent in after April 15th due to the scheduling of your appointment with your doctor. Just make sure you send in your application portion and payment, and then you can send in the medical portion after your doctor's appointment. You can indicate on the application when your doctor appointment has been scheduled. The completed medical section must be received in the BIA office no later than April 30th.

As a reminder, camp continues to grow each year. If you are planning to attend camp, it is important that you send in your application and payment as soon as possible. The $575 fee is just for camp registration. It doesn't include transportation, durable medical equipment, 1:1 coverage or other required items/services. Campers are to meet us at camp for check-in. We also encourage you to carpool if you are coming from the same area.

We are all looking forward to a great camping experience! If you have any questions, call the Brain Injury Association of Illinois office at (312) 726-5699 or (800) 699-6443. You can also reach me on the cell phone, (708)369-8360.

Camp will be here soon!

Philicia

Philicia L. Deckard, LSW CBIST

Executive Director

BRAIN INJURY ASSOCIATION OF ILLINOIS

P.O. Box 64420 ♦ Chicago, Illinois 60664-0420

312.726.5699 ♦ 800.699.6443 ♦ 312.630.4011 *fax*
e-mail: info@biail.org www.biail.org

CAMPER NAME_____

Camp FunZone Required Check List

Return with application

- ☐ Camp application
- ☐ Copy of the Insurance/Medicare card (if applicable)
- ☐ Copy of **both** sides of the **current** Medicaid card (if applicable)
- ☐ Copy of **both** sides of the **June** Medicaid card (if applicable)

  (Note: Please bring a copy of the June card with you to camp)
- ☐ Indemnification/Consents/Agreement Form
- ☐ Medical Form
  - ☐ TB documentation
  - ☐ Tetanus documentation
  - ☐ Agreement, Consent and Release Signature

Fee

☐ I am enclosing $575.00 for camp registration

(Please note this doesn't include transportation, durable medical equipment, 1:1 coverage or other required items/services)

CAMP FUNZONE
At Red Leaf
Ingleside, Illinois

DATES: Sunday, June 25, 2017 - Friday, June 30, 2017

CAMPERS:

First come, first served basis. A **registered camper** is a camper who has returned his/her completed registration forms **AND** the full camp fee, **AND** has been determined to be appropriate for the camp program. Incomplete forms, or forms received without appropriate fee will be returned. **Be sure to return the signed indemnification agreement. Please be mindful that submission of a completed application and registration fee don't guarantee an individual will be accepted for camp admission due to additional screening/review of the individual's physical and behavioral functioning/needs.**

We recommend that you make an appointment with your doctor as soon as possible.

FEE: $575.00 per camper

This amount covers room and board, general medical attention at the camp's facility, staff services, and all activities. Not included in the fee are special medications and personal needs, outside services for non-camp related incidents, personal caregiver services, rental equipment for personal needs and special diet supplements. Campers will be charged for the rental of medical equipment and supplies that are required/needed during the camp.

The Camp costs have been increased this year, but the BIA has made a minimal increase in the cost.

DUE ON or BEFORE: April 15, 2017

Registrations received after April 15, 2017 will be accepted based on space available.

Please note, due to Camp Red Leaf's schedule, all camps end on Friday this summer.

CAMP CHECK-IN/CHECK-OUT TIMES:

Check-In:	SUNDAY, June 25	3:00 p.m.
Check-Out:	FRIDAY, June 30	2:00 p.m.

CANCELLATION POLICY:

If canceled on or before April 15, 2017, the fee (except for $100 non-refundable cost) will be returned. Cancellation on or after April 16, 2017, the fee is non-refundable.

MEDICATIONS:

The **date of your last tetanus shot and TB Test are required!** All medications will be turned over to the camp's registered nurse at the time of registration on June 25, 2017. The nurse will administer all medications in accordance with the directions on the Application and/or Health Examination forms. This is in compliance with the American Camping Association, wherein they state that all medications must be stored in a locked area in the dispensary and administered by a registered nurse.

WHAT TO BRING TO CAMP:

Clothing list will be sent with Confirmation Letter when completed registration form is received.

SPECIAL DIETS:

Bring any adaptive eating equipment to camp. Because of budgetary constraints, Red Leaf is unable to purchase special foods for individual campers on special diets. Therefore, in order to keep the costs of all campers to a minimum, BIA of IL requests that campers on special diets bring their foodstuffs to camp with them, where they will be stored. **This does not apply to diabetic campers.**

When your completed application has been received, we will send a Confirmation packet that will include:

- ✓ Detailed instructions
- ✓ What to Bring to Camp
- ✓ Medication Packing Procedure
- ✓ Medication Form
- ✓ Detailed map

Brain Injury Association of Illinois
CAMP FUNZONE CAMP

CAMPER APPLICATION
June 25, 2017 – June 30, 2017

Please answer all questions in the camper application accurately and completely. The Initial section is to be completed by the individual and family /guardian. The Physical/Medical Section are to be completed & signed by both the Physician and the Camper/Guardian/Parent.

Send completed application and fee by the stated deadline to this NEW ADDRESS:
Brain Injury Association of Illinois P.O. Box 70 Palos Heights, IL 60463

Applicant's Name_____ Nickname: _____

Address:_____ Date of Birth: _____

City,State, Zip: _____ Weight: _____ Height: _____ T-Shirt size:_____

Telephone:_____ Sex ☐ M ☐ F Race: _____

Diagnosis _____

Parent/Guardian Name:_____ Home phone: _____

Address:_____ Work / Contact phone:

City,State, Zip: _____ (father): _____

(mother):_____

Where parent/guardian can be reached during camp:

Phone: _____ Health Insurance Co. & Policy # (Medicare/Medicaid

Location: _____ copy both sides of card and submit with application):

_____

Parent / Guardian Place of Employment

Firm:_____ Emergency Contact (available during camp)

Address:_____ Name: _____

City,State,Zip:_____ Address: _____

Telephone:_____ City, State, Zip: _____

Phone (work): _____

E-Mail Address: _____ (home):_____

☐ *check here if e-mail address can be shared with other campers*

Can Photos/Posts be shared on the Camper's Social Media pages?

Facebook☐ Twitter☐

BIA OF ILLINOIS INVOLVEMENT

Are you a member of the Brain Injury Association? _____

Do you attend the annual educational conference? _____

What support group do you attend? _____

Nature of Injury (Date, Cause, Rehabilitation services received following injury, etc)

TO: CAMPER/PARENT/GUARDIAN
RE: INDEMNIFICATION AGREEMENT/CONSENT/RELEASE

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING, and be aware that in signing up and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries or loss or property damage that you (or your camper) might sustain arising in any manner out of this program or the use of the facilities or equipment. This section must be filled out and signed by each participant (or their parent/guardian) or they will not be allowed to participate or use the facilities or equipment.

The **Brain Injury Association of Illinois** (hereinafter referred to as BIA of IL), an Illinois not-for-profit corporation is the sponsoring agency of a summer camp, named *Camp FunZone*, for individuals with brain injury to be held at JCYS Camp Red Leaf from Sunday, June 25, 2017 – Friday, June 30, 2017. JCYS **Camp Red Leaf** (hereinafter referred to as "Camp"), is located in Ingleside, Illinois.

As the sponsoring agency, the BIA of IL, has taken precautions to ensure that the Camp is properly organized and that suitable supervision, instruction, and equipment are provided by the Camp.

The undersigned (camp participant, parent, or guardian) expressly understands that some of the activities of the Camp are potentially hazardous, such as swimming, hiking, ropes course, rock wall and canoeing. The undersigned expressly realizes that the BIA of IL cannot warrant or guarantee

Print Camper's Name _____

_____ absolute safety against those risks inherent to a camp environment.

During the 2017 Camp session, the undersigned hereby confirms that the above-mentioned camp participant will exhibit appropriate social behavior at all times. The camp participant will neither transport onto the camp property nor be under the influence of any alcoholic beverages or illicit drugs at any time during the camp experience. If the above-mentioned camp participant is found to be under the influence of alcohol or drugs or exhibits inappropriate social behavior, he or she will be asked to leave the camp immediately. BIA of IL and the Camp reserves the right to terminate the above-mentioned camper in participating in the *2017 Camp FunZone* session anytime during the camp session if the camper is found to be abusing these regulations. In the event a camp participant is asked to leave due to the above, he/she will not be reimbursed for any portion of the 2017 camp registration fee paid in advance. In addition, if a camper abuses this regulation in two consecutive years, he/she will not be permitted to attend the Brain Injury Association of Illinois' *Camp FunZone* in the future.

For and in consideration of the Agreement to provide camp and related camp activities, the undersigned, on behalf of himself or herself, heirs, personal representatives and/or assigns, does hereby agree to indemnify and save harmless the BIA of IL (sponsoring agency), their insurers, and all others charged or chargeable with liability or responsibility from and against all claims, suits, damages, costs, losses, and expenses, in any manner resulting from or arising out of participation in the Camp at Red Leaf, in Ingleside, IL.

Signature of Camper/Guardian/Parent_____

Date_____

Parent/Guardian or Applicant Agreement, Consent, and Release

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING, and be aware that in registering and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries, loss, or property damage that you or your camper/child might sustain arising in any manner from this program or the use of the facilities or equipment. This section must be filled out and signed by each participant or their parent/guardian or they will not be allowed to participate or use the facilities or equipment.

Acknowledgement of Risk or Injury Clause—As a participant in the program, I recognize the risk and acknowledge that there are certain risks of physical injuries, including death, damages, property damage, or loss which I or my camper/child may sustain as a result of participating in any and all activities connected with such program and/or the use of the facilities or equipment.

Waiver of Claim for Injury Clause—I agree to waive and relinquish all claims that I or my camper/child may have for injuries or damages, as a result of participating in the program and/or using the facilities or equipment, against Brain Injury Association of Illinois, JCYS Camp Red Leaf., and their officers, agents, servants, employees, and affiliates.

Release from Liability Clause—I do hereby fully release and discharge Brain Injury Association of Illinois, JCYS Camp Red Leaf, and their officers, agents, servants, employees, and affiliates from any and all claims for injuries, including death, damages, property damage, or loss which may have or which may in the future accrue to me or my camper/child on account of participation in the program and/or use of the facilities or equipment.

Indemnity and Defense Clause—I further agree to indemnify and hold harmless and pay defense costs and defend Brain Injury Association of Illinois, JCYS Camp Red Leaf, and their officers, agents, servants, employees, and affiliates, from any and all claims resulting from injuries, including death, damages, property damage, and/or loss sustained by me or my camper/child and arising out of, connected with, or in any way associated with the activities of the program or the use of the facilities or equipment. The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Executive Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. **The undersigned recognizes the right of the Executive Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health, safety, or well being at camp.** The undersigned further agrees to pick up the camper immediately upon being notified of such termination. If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present **written** authorization from the undersigned.

Photographic Release—In consideration of the furtherance of the purpose of the Brain Injury Association of Illinois, I hereby grant permission to the same, to their officers, agents, and employees to take photographs or video of me or my camper/child and to use my name in connection with any and all such photographs and in connection with any news release or story, and further, to use and distribute for publication any and all such photographs, video, news releases, and stories for any purpose they may deem proper. In granting such permission, I hereby relinquish any right, title, and interest I may have in such photographs, video, news releases, and stories and grant the Brain Injury Association of Illinois, the right to use these products.

☐ **Yes, I give permission for myself, or my camper/child to be photographed.**

☐ **No, I do not give permission for myself, or my camper/child to be photographed.**

_____ _____

Signature of Camper Date

_____ _____

Signature of Guardian / Parent Date

ADDITIONAL INFORMATION

Please share additional information that you feel would be beneficial for the staff to be aware of during camp. Please describe fears, likes, dislikes, or habits that you feel would be helpful for the staff to know. Any suggestions you may have for assisting the camper's smooth transition to the camp are appreciated.

Brain Injury Association of Illinois
P.O. Box 64420 Chicago, IL 60664-0420
Phone: 312.726.5699 Fax: 312.630.4011
www.biail.org

BIA of Illinois at Camp Red Leaf

Intake Questionnaire

Please type or print legibly – Use additional paper if needed

Name_____
(first) *(middle)* *(last)*
Age _____ Male ☐ Female ☐ Date of birth ____/____/____

Nickname (if one is used)_____

Primary Diagnosis_____

Secondary or Other Diagnosis_____

Other Conditions or Concerns (Including psychiatric)_____

ACTIVITY LEVEL

☐ Has typical attention span for his/her age [or] ☐ has a very short attention span
☐ Is underactive (needs motivation to participate) [or] ☐ is overactive
☐ Is easily distracted by sights, sounds, people, etc.

Please describe how you manage his/her activity level, motivate him/her to participate, etc._____

_____

_____

Is the camper able to stay with a group throughout the day, or has a tendency to wander?_____

_____

If wanders, what are ways to redirect attention?_____

_____

COMMUNICATION SKILLS *(examples/comments)*

☐ Uses complete sentences ☐ Understands complete sentences _____
☐ Understands 2-3word phrases _____
☐ Uses single words ☐ Understands single words_____
☐ Uses vocalizations, sounds, etc. _____
☐ Uses sign language ☐ Understands sign language _____
☐ Uses/understands gestures, points, etc. _____
☐ Uses pictures or word cards _____
☐ Uses special systems such as a communication board _____
☐ Writes to communicate ☐ Is able to read _____
☐ Facilitated communication (devices used; who usually acts as facilitator?) _____

SLEEP

Are there any unusual sleeping patterns or positions we should know about?_____

_____

How many hours does the applicant sleep at night (on average)?_____

Office Use Only

Session(s):_____
Received:_____
Reviewed:_____
Cabin:_____

Brain Injury Association of Illinois
P.O. Box 64420 Chicago, IL 60664-0420
Phone: 312.726.5699 Fax: 312.630.4011
www.biail.org

MOBILITY

☐ Walks/Runs Independently ☐ Needs Assistance Walking/Running ☐ Needs Assistance on Steps
☐ Uses Walker ☐ Wears Braces On Legs ☐ Uses Wheelchair

If camper uses a wheelchair, please describe transfer procedures._____

LEVEL OF SUPERVISION REQUIRED FOR TIME AT CAMP
(CHECK ONLY ONE)

☐ Can function totally independently and in a group in all or most settings with little supervision
☐ Can function independently for short periods of time and in a group with 1 staff and several others the rest of the time
☐ Generally can function in a group with supervision and 2-3 others; needs one-to-one supervision for some activities
☐ Needs one-to-one supervision throughout the day

(Check in addition to one of the above if applicable)

☐ Needs more than one staff with him/her when agitated or upset

FURTHER EXPLANATION OR COMMENTS REGARDING ANY OF THE ABOVE:

In the following sections, please check off any statements that apply. You may check off as many as are needed. Please answer thoroughly giving examples. Use and attach additional paper if necessary.

TOILETING *(comments)*

☐ Uses toilet independently ☐ Is partially toilet trained ☐ Needs to be reminded_____
☐ Needs some assistance using the toilet _____
☐ Uses the toilet on a schedule (What is the schedule?)_____
☐ Does not use toilet at all (uses incontinent briefs, etc.)_____
☐ Needs enemas or suppositories _____
☐ Is independent in menstrual care (if applicable) _____

How does he/she let you know they need to go to the restroom? _____

Mealtimes *(comments)*

☐ Has a poor appetite ☐ Has a good appetite ☐ Has an excessive appetite
☐ Has good table manners ☐ Has inappropriate table manners (throws food, grabs food, etc.)
☐ Fed through a G-Tube _____
☐ Can use ☐ fork ☐ spoon ☐ knife ☐ needs food cut
☐ Takes portions independently ☐ Drinks from a cup without assistance
☐ Has difficulty with choking or swallowing_____
☐ Uses special utensils (Please label and send to camp)_____

What are some favorite foods and drinks? _____

What other special dietary needs does he/she have? (no sugar, no meat, limit servings, etc.) _____

Brain Injury Association of Illinois
P.O. Box 64420 Chicago, IL 60664-0420
Phone: 312.726.5699 Fax: 312.630.4011
www.biail.org

Dressing

☐ Has no dressing problems ☐ Can choose own clothes

☐ Can put on ☐ underwear ☐ socks ☐ shirt ☐ pants

☐ Can button ☐ snap ☐ zip ☐ tie shoes

☐ Can undress partially ☐ Can undress completely ☐ Needs lots of assistance dressing

Please describe what assistance is needed in (un)dressing: _____

_____

BEHAVIOR

Please indicate how often, if ever, the following behaviors occur and how staff should respond.
It is most beneficial for you to provide accurate and detailed information in order to maintain consistent management.

BEHAVIOR	NEVER	SELDOM	OFTEN	EXPLAIN/DETAILS
-Self Abuse	☐	☐	☐	_____
-Can be a leader	☐	☐	☐	_____
-Bites others	☐	☐	☐	_____
-Scratches, pinches, or hits others	☐	☐	☐	_____
-Uses appropriate touch	☐	☐	☐	_____
-Grabs other people	☐	☐	☐	_____
-Has good manners	☐	☐	☐	_____
-Uses inappropriate language	☐	☐	☐	_____
-Inappropriate sexual behavior	☐	☐	☐	_____
-Does not like to be touched	☐	☐	☐	_____
-Prefers to be alone	☐	☐	☐	_____
-Runs away or darts	☐	☐	☐	_____
-Enjoys social gatherings	☐	☐	☐	_____

Please describe in more detail these or any other challenging behaviors we should know about_____

_____

_____

What usually triggers challenging behaviors?_____

_____

What are effective responses to challenging behaviors?_____

_____

What are two or three effective rewards?_____

_____

Brain Injury Association of Illinois
P.O. Box 64420 Chicago, IL 60664-0420
Phone: 312.726.5699 Fax: 312.630.4011
www.biail.org

ACTIVITIES

What are some of the applicant's most favorite activities and personal interests? _____

_____

☐ I am unsure how he/she does in the pool/lake.

☐ Applicant swims well

☐ Fears water [and/or] ☐ will not get into water willingly

☐ Applicant cannot swim; must remain in the shallow water

☐ Needs to wear a life jacket at all times *(mark this item if applicant has a seizure disorder)*

☐ Applicant has very sun sensitive skin ☐ Somewhat sun sensitive skin ☐ Skin is not sun sensitive

Some favorite outdoor activities are _____

☐ Applicant has good fine motor skills

☐ Applicant has poor fine motor skills ☐ Needs hand-over-hand assistance

Please list any indoor games/activities that the applicant particularly likes or specifically dislikes (playing cards, painting, etc.)

_____

Activities applicant does not like are _____

MEDICAL CONCERNS

Please describe any health problems that the participant has (seizures, diabetes, medication side effects, etc.): _____

_____

Medications taken _____

Medication times _____

Please list all of the participants known allergies to food, medication, etc. and his/her reaction: _____

_____

Are there any blood or body fluid precautions? ◯ Yes ◯ No

If yes, what type? _____

Is the applicant a smoker? ◯ Yes ◯ No

Comments (who manages their cigarettes, do they smoke on a schedule, used as a reward?): _____

_____

THANK YOU FOR COMPLETING THIS FORM THOROUGHLY. Is there anything else we should know in order to provide the best care and experience possible? Feel free to fill the rest of this page, as well as add additional paper as you need to.

_____

_____

_____

_____

_____

_____

_____

_____

Name of person filling out form: _____ Phone: _____

Relationship to Camper _____

Signature: _____ Date: _____

BRAIN INJURY ASSOCIATION OF ILLINOIS

P.O. Box 64420 ♦ Chicago, Illinois 60664-0420

312.726.5699 ♦ 800.699.6443 ♦ 312.630.4011 *fax*
e-mail: info@biail.org www.biail.org

To the Physician:
Please keep in mind when completing the following Physician & Medical section that the Brain Injury Association of Illinois Camp was developed for individuals who have sustained a brain injury and who may have physical and cognitive impairments. All activities are supervised.

If you have questions or require additional information, please call the Brain Injury Association of Illinois office. The office number is (312) 726-5699, and the fax number is (312) 630-4011.

Thank you for your time and assistance in completing this portion of the camp application.

Best regards,

Philicia L. Deckard, LSW CBIST
Executive Director

_____
Camper Name

PARENT/GUARDIAN or APPLICANT AGREEMENT, CONSENT, and RELEASE

Please read this section carefully, and be aware that in signing up and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries or loss of property damage that you (or your family member) might sustain arising in any manner out of this program or the use of the facilities or equipment. This section must be filled out and signed by each participant (or parent/spouse/guardian) or they will not be allowed to participate or use the facilities or equipment. Acknowledgment of Risk or Injury Clause- As a participant in the program I recognize the risk and acknowledge that there are certain risks of physical injuries, including death, damages, property damage, or loss which I (or my family member) may sustain as a result of participating in any and all activities connected with such program, or the use of the facilities or equipment. Waiver of Claim for Injury Clause- I agree to waive and relinquish all claims that I (or my family member) may have for injuries or damages, as a result of participating in the program or using the facilities or equipment against the Brain Injury Association of Illinois, Camp Red Leaf, and its officers, agents, servants, employees, and affiliates. Release from Liability Clause-I do hereby fully release and discharge the Brain Injury Association of Illinois, Camp Red Leaf, and its officers, agents, servants, employees, and affiliates, from any and all claims for injuries, including death, damages, property damage, or loss which may have or which may in the future accrue to me (or my family member) on account of participation in the program or use of the facilities or equipment. Indemnity and Defense Clause-I further agree to indemnify and hold harmless and pay defense costs and defend the Brain Injury Association of Illinois, Camp Red Leaf, and its officers, agents, servants, employees, and affiliates, from any and all claims resulting from injuries, including death, damages, property damage or loss sustained by me (or my family member) and arising out of, connected with, or in any way associated with the activities of the program or the use of the facilities or equipment. The undersigned does consent that photographs, video and/or motion pictures may be taken of the above applicant during the camp period, and said photographs, video or motion pictures may be published in newspapers, magazines, television, publicity releases and/or other media. The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health and safety at camp. The undersigned further agrees to pick up the camper immediately upon being notified of such termination. If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned.

I do hereby authorize (name, address and phone) _____

_____

_____ to pick up the camper, _____

_____ _____

Signature of Parent, Guardian, or Applicant Date

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _____ (date)

Brain Injury Association of Illinois
P.O. Box 70
Palos Heights, IL 60463

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name First Middle Last (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

***If your camper has not been fully immunized, please sign the following statement*: I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

***Please explain "Yes" answers in the space below*,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

Rev. 1/2007 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:** _____ **Initials:** _____

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _____ (date)

Brain Injury Association of Illinois
P.O. Box 70
Palos Heights, IL 60463

***To Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2)** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.*

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐Yes ☐No (**If "No," date of last physical**: _____ (Month/Day/Year))

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐No ☐Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date: _____

Rev. 2/07 LEE/EAW

Camper Name (First / Middle / Last)

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Dear Parents/Guardians:

Thank you for enrolling your child in camp this summer. You noted on your registration form that your child will be taking medication during the week of camp. We are asking parents/ guardians to complete a Medication Permission Form for Dispensing, plus be sure to bring the medications in their original medication container at check-in.

The intent of this policy is to provide a smooth check in and reduce the risk of confusion while dispensing medication.

1. Fill out Medication – Permission Form for dispensing, please be as specific as possible with medication name, dispensing instruction, description of medication, possible side effects.

2. Bring each medication to camp in the original prescription container.
The medications will be returned to you at check-out. If your child takes **liquid medicine**, you must supply Camp Red Leaf with a bottle & spoon or dispensing cup labeled with your child's name.

3**. Bring the medication or liquid medicine to the check-in for the session the camper is signed up for. Medication cannot be dispensed at camp unless it is provided in the original medication container and a permission form is completed and signed.**

4. Please call me if you have any questions.

5. Please send us a copy of your insurance card.

Best regards,

Philicia L. Deckard, LSW CBIST
Executive Director
Brain Injury Association of Illinois

Brain Injury Association of Illinois Camp FunZone
P.O. Box 64420 Chicago, IL 60664-0420
Phone: 312.726.5699 Fax: 312.630.4011

Medication Administration Form

Camper's Name: _____

Emergency Contact Phone Number: _____

****A PHYSICIAN'S SIGNATURE MUST BE INCLUDED ON THIS FORM****

Please check how the camper usually takes his/her medication? ☐**With drink** ☐**In food** ☐**Other**_____

ALLERGIES: _____

Medications (Please print and include medication name and dosage to be given)	Su	M	T	W	Th	F
Breakfast (8:30am)						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Lunch (12:30pm)						
1.						
2.						
3.						
4.						
Dinner (5:30pm)						
1.						
2.						
3.						
4.						
5.						
Bedtime (8:30pm)						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Physician's Name: _____ **Physician's Phone:** _____

Physician's Signature: _____ **Date:** _____