

BRAIN INJURY ASSOCIATION OF ILLINOIS

P.O. Box 70 ♦ Palos Heights, Illinois 60463

e-mail: info@biail.org

312.726.5699 ♦ 800.699.6443 ♦ 312.630.4011 *fax*

www.biail.org

CAMP FUNZONE

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 (if ordered by your physician). Remember, the **deadline for camp registration is May 17, 2019**. The signed medical portion of the application can be sent in after May 17th 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. Your registration is not complete until the full application and payment have been submitted.

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 \$650 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 (call or text), (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 \$650.00 for camp registration
(Please note this doesn't include transportation, durable medical equipment, 1:1 coverage or other required items/services)

Applications can be mailed to the BIA of Illinois:

**BIA of Illinois
PO Box 70
Palos Heights, IL 60463**

Applications can be scanned and returned to the BIA of Illinois

info@biail.org

Applications can also be faxed to

312.630.4011

CAMP FUNZONE
Timber Pointe Outdoor Center
Hudson, Illinois

DATES: Sunday, June 16, 2019 - Friday, June 21, 2019

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: \$650.00 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 fee has been increased for the first time in eight years due to a camp site cost increase.

DUE ON or BEFORE: May 17, 2019

Registrations received after May 17, 2019 will be accepted based on space available.

Please note, due to Timber Pointe's schedule, all camps end on Friday at 10am this summer.

CAMP CHECK-IN/CHECK-OUT TIMES:

Check-In:	SUNDAY, June 16	TBD
Check-Out:	FRIDAY, June 21	10:00 a.m.

CANCELLATION POLICY:

If canceled on or before May 17, 2019, the fee (except for \$100 non-refundable cost) will be returned. Cancellation on or after May 1, 2019, 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 16, 2019. 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, Timber Pointe Outdoor Center 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
- ✓ Prescription Medication Procedures and Requirements
- ✓ Medication Form
- ✓ Detailed map

**Brain Injury Association of Illinois
CAMP FUNZONE CAMP**

CAMPER APPLICATION

June 16, 2019 – June 21, 2019

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 (the last 7 pages) 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 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: _____
Email address: _____ 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: _____
Address: _____
City,State,Zip: _____
Telephone: _____
E-Mail Address: _____

Emergency Contact (available during camp)

Name: _____
Address: _____
City, State, Zip: _____
Phone (work): _____
(home): _____

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

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 the Easter Seal Camp from Sunday, June 16, 2019 – Friday, June 21, 2019. **Timber Pointe Outdoor Center** (hereinafter referred to as “Camp”), is located on Lake Bloomington, in Hudson 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 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 2019 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 *2019 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 2019 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 Easter Seals - UCP Timber Pointe Outdoor Center, Hudson, 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, National Easter Seals and Easter Seals Inc., and their officers, agents, servants, employees, and affiliates.

Release from Liability Clause—I do hereby fully release and discharge Brain Injury Association of Illinois, National Easter Seals and Easter Seals Inc., 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, National Easter Seals, Easter Seals Inc., 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. This release does not include consent for Easter Seals to photograph and use for their purposes.

Yes, I give permission for myself, or my camper/child to be photographed by Brain Injury Assn of IL.

No, I do not give permission for myself, or my camper/child to be photographed by Brain Injury Assn of IL

Signature of Camper

Date

Signature of Guardian / Parent

Date

CAMPER LEVEL OF CARE

Which best describes the level of care that your camper needs for Activities of Daily Living and Behavior Support?
(Please indicate best match only)

___ **Independent**

Individual is independent in mobility and activities of daily living, needing only prompts and reminders. You are ambulatory or able to use an assistive device, such as a wheelchair or walker independently.

___ **Minimal Assistance**

Individual needs occasional support with personal care needs, such as help getting dressed/showering/toileting, having items setup for you from clothes to food, or prompts and reminders. You do not need continuous mobility or behavioral support.

___ **Moderate Care**

Individual needs assistance from staff to utilize mobility devices or to ambulate or for behavior support/intervention. Occasional support with personal care needs, such as help getting dressed/showering/toileting, having items set up for you from clothes to food, or prompts and reminders is part of your normal routine.

___ **Constant Care: One-to-One Supervision & Assistance**

Individual has medical conditions, behavior disorders, a severe cognitive delay, and/or multiple disabilities that require one-to-one support to safely function in an active group setting. Individual needs continuous assistance from staff to utilize mobility devices, ambulate, and/or for behavior support/intervention.

The BIA Camp program offers a wide range of activities including: arts and crafts, campfires, swimming, boating, barnyard activities, nature hikes, hayrides, horseback riding, fishing, sports and group activities - all under the safe supervision of a 1:1 counselor. Camp counselors are paired 1:1 with campers 24-hours a day. Activities and routines are planned to meet the recreational, social, cognitive, and physical needs of each camper. The 1:1 counselor ensures that the camper's daily routine is maintained at camp. The Brain Injury Association of Illinois is a contract camp at Timber Pointe Outdoor Center. Our campers must meet our admission criteria as well as the admission criteria required by Timber Pointe Outdoor Center. For the camper who requires 1:1 Supervision and Assistance, an additional fee is required to cover the cost of the 1:1 counselor. The cost for a 1:1 counselor is an additional \$300. There is a limited number of 1:1 coverage slots available.

Contact the BIA of Illinois office if you have questions about the level of care that your camper requires, 312.726.5699 or info@biaill.org

The Brain Injury Association of Illinois and Timber Pointe Outdoor Center care about the safety and well-being of each camper. It is important that the above information is honestly and accurately communicated, or the application may be denied. Any information related to routines, behavioral issues, communication barriers, and medical problems need to be addressed. If camper information is found to be inaccurate upon arrival or during the week, or if the camper displays unmanageable behavior or behavior that poses a threat to himself/others, the camper will be denied camp admission or sent home. Camp fees will not be refunded, and the camper's family will be contacted to make arrangements for pick-up.

I have read the above information and have thoughtfully considered my care needs or the needs of my camper. To the best of my ability, I have chosen the appropriate level of care.

Signature of Camper or Guardian / Responsible Party / Parent

Date

- All important information relative to the camper's health and well-being should be on this application.
- Please DO NOT rely on verbal instructions at the time of check-in to communicate important information about your camper.
- In order to process this application, a photo of the camper must be attached with the application.

CAMPER INFORMATION

Camper Name: _____

Age: _____ Gender: Male Female

How did you find out about Brain Injury Assn of Illinois Camp program?

Support Group Word of Mouth/Friends Internet Search
 School Case Worker BIA of IL website

Other (please list): _____

Is this the camper's first time attending the BIA camp? Yes No

Has the camper ever been to any other camp before? Yes No

Camps outside of Illinois? Yes No

Has the camper ever been separated from his or her family before? Yes No

If yes, any response/reaction:

Are there any anticipated problems with homesickness? Yes No

If yes, suggestions to ease the transition:

Does the camper attend school? No If Yes, Where? _____

Is the camper employed? No If Yes, Type of Work? _____

Is the camper bringing a service dog to camp? No If Yes, What is Name/Breed _____

What group experience has the camper had? _____

What are the camper's favorite things to do or learn about? _____

HEALTH HISTORY

Age: _____

Weight/lbs: _____

Height: _____

REQUIRED: Primary Diagnosis (medical, no abbreviations): _____

Secondary Diagnosis (if any): _____

Other conditions or concerns (including psychiatric): _____

Allergies (Medication, Environment, or Animals): _____

Comments/Allergy Reactions: _____

SEIZURE INFORMATION

Seizure Disorders: _____ Does Not Apply Date of Last Seizure _____

Tonic-Clonic (Grand Mal) Non-Convulsive (Petit Mal) Psychomotor Nocturnal Mixed

Typical Seizure Frequency: _____ Typical Length of Seizure: _____

Known Triggers, PRN Medications (if any) and protocol to follow? _____

MOBILITY AND SPECIAL APPLIANCES

Indicate all that apply to the camper:

Walks/Runs Independently Uses Walker/Crutches/Cane Wears AFOs or Braces Prosthesis

Uses Wheelchair: Manual Power When: For Long Distances At All Times

Who Maneuvers: Self Others

Mobility Comments: _____

TRANSFER INFORMATION

Transfers Independently Standby Assistance Pivot (1 person) Two Person Hoyer Lift

Other/Comments: _____

COMMUNICATION

Uses complete sentences

Understands complete sentences

Understands 2-3 word 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 adaptive systems such as a communication board

Writes to communicate

Able to read

Facilitated communication (devices used; who usually acts as facilitator?) _____

Additional Comments Regarding Communication: _____

DRESSING

Has No Difficulty Dressing

Can Choose Own Clothes

Able to put on:

Underwear

Socks

Shirt

Pants

Able to:

Button

Snap

Zip

Tie Shoes

Able to Undress:

Partially

Completely

Needs Total Assistance Dressing

Are there any ADLs (Activities of Daily Living/Programs) that should be continued while at camp: _____

Please describe what assistance is needed to dress and/or undress: _____

MEAL TIME

Please note, we discourage campers bringing high energy/caffeine drinks and high sugar snacks to camp.

Food Allergies / Sensitivity: _____

Food Likes: _____

Food Dislikes: _____

Typical appetite is: Large Moderate Small

Is camper able to indicate the amount of food and liquid intake he/she desires? Yes No

Camper is able to use: Fork Spoon Knife

Uses Special Utensils (please label and bring to camp)

Takes Portions Independently Needs Food Cut Drinks From Cup Uses Straw

Needs Liquids Thickened If yes, what consistency? _____

Diet: Standard Chopped Blended/Pureed Low Salt

Low Calorie Low/No Sugar Other

Uses G-Tube (*Please attach the exact schedule so we can contact you with any questions prior to arrival*)

Special Diets: If your camper requires a special diet, please indicate _____

Mealtimes Comments/Restrictions/Allergy Reactions: _____

TOILETING/SHOWER

Please bring all supplies and/or equipment (bedpan, briefs, wipes, bed pads, hygiene supplies, etc.) for the week. Campers are encouraged to bring electric razors to camp if they require assistance with shaving.

Uses Toilet Independently

Needs to be Reminded / Cued

Needs some assistance using the toilet (Type of Assistance) _____

Uses the toilet on a schedule (What is the schedule?) _____

Does not use toilet at all (Uses incontinent briefs, etc.)

Uses Catheterization, Enemas, or Suppositories (Please describe schedule) _____

Is independent in menstrual care (if applicable)

Frequency of bowel movements: _____

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

Camper Needs Assistance With: Shampooing Hair Soaping

Adjusting Water Temperature Brushing Teeth

Needs Complete Assistance in the Shower Needs Verbal Cues

Camper Can Shower Independently

Toileting / Shower Comments: _____

BEDTIME ROUTINE

Camper's Typical Bedtime: _____ Awakens At: _____ Sleeps: ____ hours a night
Does the Camper sleep through the night? ___Yes ___No
Does the Camper experience episodes of night terrors or anxiety? ___Yes ___No
Does the Camper display any unusual nighttime behaviors/activities? ___Yes ___No
Does the camper require special care during the night? ___Yes ___No
Please describe bedtime routine at home: _____

Additional Comments / Explanation _____

Does the camper require a hospital bed? ___Yes ___No
Does the camper require a bed rail? ___Yes ___No

Please note there is an additional charge for hospital bed and bed rail rental

ACTIVITIES

Please note that life jackets are required to be worn by all campers while at the waterfront and/on the boats, and helmets are required during horseback riding. While we encourage campers to participate in all activities, campers will not be made to participate in an activity if they do not want to participate.

Swimming:

___Camper Swims Well ___Camper cannot swim, but will go into water
___I am unsure how the camper does in a pool

The Camper: ___Fears Water ___Will not willingly get into water
___Needs to wear a life jacket at all times (Please mark this item if camper has a seizure disorder)

The Camper has: ___very sun-sensitive skin ___Somewhat sun-sensitive skin
___Skin is not sun-sensitive

The Camper has: ___good fine motor skills ___poor fine motor skills
___Requires hand-over-hand assistance

Please list any favorite outdoor games/activities: _____

Please list any favorite indoor games/activities that the camper likes: (playing cards, painting, etc.): _____

Activities the camper dislikes: _____

BEHAVIOR STATUS / INFORMATION

Please provide accurate and detailed information in order to maintain consistent behavior.

Please attach established behavior plans and feel free to add comments on an additional piece of paper.

Please indicate how often the following behaviors occur and how staff should respond.

	Never	Seldom	Often	Explain/Details
Has Good Manners				
Enjoys Social Gatherings				
Does Not like to be Touched				
Prefers to be Alone				
Runs Away or Darts				
Wanders				
Grabs Others				
Scratches, Pinches, or Hits				
Bites Others				
Self Abusive Behavior				
Emotional (Laughing, Weeping)				
Uses Inappropriate Words / Language				
Inappropriate Social Behavior				
Confabulates				
Verbal Perseveration				
Other Behaviors:				

Please describe in detail these or any other challenging behaviors we should know about: _____

What usually triggers challenging behaviors? _____

What are effective responses to challenging behaviors? (Please indicate if more than one staff needs to be present when the camper is agitated) _____

What are two or three effective rewards? _____

BRAIN INJURY ASSOCIATION OF ILLINOIS

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

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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. The completed and signed medical portion can be scanned and returned to info@biail.org.

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, National Easter Seals, Easter Seals, Inc. 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, National Easter Seals, Easter Seals Inc. 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, National Easter Seals, Easter Seals Inc 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

PHYSICIAN & MEDICAL SECTION

MEDICATION FORM, PHYSICIAN FORM, MEDICAL CONSENT, PERMISSION TO TREAT FORM, AND PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION FORM

The physician must complete and sign all 3 forms in the Camper Physical/Medical Section.

The Parent/Guardian is to complete and sign the Permission to Treat form

The Medical section must be submitted to the BIA office in its entirety. The application will not be accepted if the section isn't completed.

At Check-In, all medications must be

1. In original containers
2. Placed in one Ziploc bag with Camper's Name written on bag

Please note: A camper may not be admitted to camp, if medications are not packaged correctly or if the updated Medication form doesn't accompany the medications.

While at camp, all medications are given to participants at scheduled times per physicians orders.

Camper's Name _____

Daytime Phone _____ Evening Phone _____

Physician _____ Physician Phone _____

(Please Print. The Physician MUST sign bottom of this form)

How does the camper usually take medication?

Chews With Liquid On Food In Food

Other (Explain) _____

Allergies– Please Indicate All:

To Drugs: _____

Environment: _____

To Food: _____

Date of TB Test (must be within 3 months of camp) _____

Date of Last Tetanus vaccination _____

List the medications below exactly as written on the prescription container label.
 List the Camper's CURRENT MEDICATIONS, DOSAGE, and TIME for administration.

MEDICATIONS	SU	M	T	W	R	F	SA
1 Breakfast (8:30am)							
2							
3							
4							
5							
6							
7							
8							
1 Lunch (12:30)							
2							
3							
4							
5							
6							
7							
8							
1 Dinner (5:30pm)							
2							
3							
4							
5							
6							
7							

MEDICATIONS	SU	M	T	W	R	F	SA
1 Bedtime (9:00pm)							
2							
3							
4							
5							
6							
7							
8							

The following sections **MUST** be reviewed and signed by a physician **WITHIN 3 months** of the camp program. This Physical Form can be sent to our office after the application, however, it must be received by our office **no later than three weeks prior to the start of the camper's program.**

HISTORY

How would you assess the applicant's current health? (circle) GOOD FAIR POOR

List any chronic health problems (asthma, pressure sores, cough, constipation) and treatments of which the nurse should be aware: _____

Has there been any recent exposure to a contagious disease? Yes No

If yes, please explain: _____

Is the applicant a carrier of any infectious condition? Yes No

If yes, please explain: _____

Are the applicant's immunization records up-to-date and complete? Yes No

Please list the dates (Month/Date/Year) of the last time the applicant had the following immunizations or tests. If the applicant has not had the tests or immunizations please indicate N/A:

_____ Diphtheria, Pertussis & Tetanus (DPT)

_____ Diphtheria & Tetanus (Td) or (TD)

_____ Oral Polio

_____ Combined Measles & Rubella (MR)

_____ Combined Measles/Mumps/Rubella (MMR)

_____ Rubeola (Red Measles) Live Virus Vaccine

_____ Rubella (3 day or German Measles)

_____ Mumps

_____ TB Skin test

_____ Hepatitis B

ALLERGIES

Does the applicant have any known allergies? Yes No

Life Threatening? Yes No

EpiPen? Yes No

If yes, describe the allergies and their reactions: _____

SEIZURES

Does the applicant have (or a history of) seizures? Yes No

If yes, answer the following questions:

Current Status (i.e. active, controlled) _____

Type of Seizure _____

Frequency _____

Duration _____

Date of last seizure _____

Describe typical reactions before, during, and after seizure _____

RESTRICTIONS

Has the applicant been hospitalized or treated in an emergency room during the last year? Yes No

If yes, please explain _____

Are there any physical conditions, past operations or injuries which might restrict camp activities? Yes No

If yes, please explain _____

Please circle any restricted program area: Swimming Athletics Boating/Canoeing

Supervised Horseback Riding Judo Supervised Zip Line /Ropes Challenge

Other Programs/Activities (Please specify) _____

*Please keep in mind that all camp activities will be supervised and adapted as necessary based on the camper's needs and interests.

MEDICAL CONSENT

(This section must be COMPLETELY filled in and signed by the Physician)

Name of Camper: _____

Date of Most Recent Physical Exam (Must be within 3 months of Camp) _____

When seen by me on this date, the camper was free from any contagious or infectious disease or condition, and is capable of participation at Camp. The above medications listed are the medications currently prescribed for the Camper. The Camper does not display any behaviors that might harm himself or others.

Physician's Signature _____ Date _____

Physician's Name (Please print) _____

Office Phone _____ Emergency Phone _____

Address _____

City/State/Zip Code _____

PERMISSION TO TREAT

I, _____, hereby give permission to the medical personnel selected to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the person I hold custody of, _____ (Camper).

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature

Date

I, _____ do NOT give permission to treat.

Parent/Guardian Signature

Date

Family / Guardians will be called to pick up their campers, or campers will be taken to the emergency room if any of the following symptoms / behaviors occur or are reported

Fever of 100.4° or higher for 24 hours

Severe nausea/vomiting/diarrhea

Uncontrolled asthma

Strep-throat

Extreme panic attacks

Pink Eye (itchy, red eyes that do not get better with allergy treatment)

Unmanageable Behavior (that puts the camper or others at risk of injury)

Self-injurious Behavior (actual or threats of)

Broken/possible broken bones

Uncontrolled pain

Flu-like symptoms

Severe allergic reactions

Exposure to hazardous materials

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

This permission must first be signed by the Physician, and then Parent/Guardian

I, _____ (Physician), hereby give permission for Brain Injury Assn of IL and Timber Pointe Outdoor Center to administer the following over-the-counter medications if medical personnel deem it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Physician's Signature (Required)

Date

Parent / Guardian Signature

Date

Medical Need:	To Be Treated With:
Abrasions, Scratches, Lacerations (minor)	<u>Apply Triple Antibiotic Ointment</u>
Allergic Reaction: Severe reaction with symptoms of difficulty breathing, cyanosis, shock, hives, itching. OR Campers with known allergy.	<u>Epinephrine, EpiPen</u>
Allergic Reaction: Mild, NO Respiratory Symptoms	<u>Benadryl, Hydrocortisone Cream</u>
Asthma	Albuterol Nebulizers: Dosage based on weight. Albuterol 5mg/mL; 0.1-0.15mg/kg in 2 cc of saline q 4-6 hours, maximum 5.0mg
Bee Sting/Wasp Stings	<u>Sting Ease</u>
Cold Symptoms, Runny Nose, Cough, Allergies, Nasal Congestion	<u>Sudafed Cold & Allergy, For Environmental Allergies: Loratadine</u>
Constipation	<u>Dulcolax or Bisacodyl Tabs, Dulcolax Suppository, Fleets Enema, Glycerin Suppository, Milk of Magnesia</u>
Cough	<u>Robitussin (guaifenesin)</u>
Cramps: Menstrual or Muscle	<u>Ibuprofen</u>
Diaper Rash	<u>Bordeaux's Butt Paste</u>
Diarrhea	<u>Antidiarrheal Caplets or Immodium</u>
Ear Aches	<u>Tylenol</u>
Eye Irritation– Minor	<u>Normal Saline (eye drops) or Visine (eye drops)</u>
Fever –Greater than 100° F	<u>Acetaminophen</u> : Isolate in infirmary and observe. If Temp remains 100.4° or greater for 24 hours, send home (camper or staff).
Fungal Skin Irritation: (jock itch, ringworm, athletes foot)	<u>OTC Antifungal Cream</u>
Headaches	<u>Acetaminophen, Ibuprofen</u>
Heartburn/Acid Indigestion/Sour Stomach	<u>Tums/Roloids, Mylanta/Maalox, Zantac 75</u>
Hemorrhoids	<u>Anusol Cream, Preparation H Suppositories</u>
Hypoglycemia	<u>Glucose tabs or instant Glucose Gel</u> : For hypoglycemic reaction: Blood glucose check p.m., give additional carbohydrates immediately, for severe insulin-induced hypoglycemia resulting in coma, transport to Emergency Room.
Insect Bites	<u>Benedryl Cream, insect repellent</u>
Lice	<u>Nix, RID, Clear, R&C Lice Control</u>
Mouth Sores	<u>Blistex or Camphophenique</u>
Muscle Strains/Arthritis	<u>Absorbine Jr. Apply topically TID pm, Myoflex or Analgesic Balm</u>
Nausea/Vomiting	<u>Maalox Mylanta, Pepto Bismol</u>
Poisoning	Call Poison Control Center– 1-800-222-1222
Rash	<u>Caladryl Cream, Calamine Lotion/Spray, Hydrocortisone Cream 1%</u>
Restlessness/Insomnia	<u>Benadryl</u>
Sore Throat	Warm Salt Water, Throat Lozenges, Chloraseptic Spray
Sun Protection	Sun screen
Vaginal Itching	<u>Vagisil Cream</u>

