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

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 May 15, 2015**. The signed medical portion of the application can be sent in after May 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 June 2nd.

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 $450 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

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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 $450.00 for camp registration
(Please note this doesn't include transportation, durable medical equipment, 1:1 coverage or other required items/services)

Raffle

___ Yes, I'm interested in selling raffle tickets to assist the Brain Injury Association of Illinois Camp program.

CAMP FUNZONE
Timber Pointe Outdoor Center
Hudson, Illinois

DATES: Sunday, June 21, 2015 - Friday, June 26, 2015

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: $450.00 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 kept the Camp registration fee at the same price as in the past several years.

DUE ON or BEFORE: May 15, 2015

Registrations received after May 15, 2015 will be accepted based on space available.

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

CAMP CHECK-IN/CHECK-OUT TIMES:

Check-In:	SUNDAY, June 21	3:00 p.m.
Check-Out:	FRIDAY, June 26	2:00 p.m.

CANCELLATION POLICY:

If canceled on or before May 15, 2015, the fee (except for $100 non-refundable cost) will be returned. Cancellation on or after May 16, 2015, 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 21, 2015. 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
- ✓ Medication Packing Procedure
- ✓ Medication Form
- ✓ Medication Envelopes
- ✓ Detailed map

Brain Injury Association of Illinois

CAMP FUNZONE CAMP

CAMPER APPLICATION

June 21, 2015 – June 26, 2015

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:

Brain Injury Association of Illinois, P.O. Box 64420, Chicago, IL 60664-0420

Applicant's Name_____

Address:_____

City,State, Zip: _____

Telephone:_____

Nickname: _____

Date of Birth: _____

Weight: _____ Height: _____ T-Shirt size:_____

Sex: M F Race: _____

Diagnosis _____

Parent/GuardianName:_____

Address:_____

City,State, Zip: _____

Home phone: _____

Work / Contact phone:

(father): _____

(mother):_____

Where parent/guardian can be reached during camp:

Phone: _____

Location: _____

Health Insurance Co. & Policy # (Medicare/Medicaid copy both sides of card and submit with application):

_____

Parent / Guardian Place of Employment

Firm:_____

Address:_____

City,State,Zip:_____

Telephone:_____

E-Mail Address: _____

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

Emergency Contact (available during camp)

Name: _____

Address: _____

City, State, Zip: _____

Phone (work): _____

(home):_____

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 the Easter Seal Camp from Sunday, June 21, 2015 – Saturday, June 26, 2015. **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 2015 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 *2015 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 2015 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.

___ 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

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 $250.

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

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 (1person) _Two Person _Hoyer Lift

_Other/Comments:_____

_____

Does the Camper have a history of:

		Yes	No			Yes	No
1	Asthma			15	Frequent Headaches		
2	Frequent Colds			16	Frequent Ear Infections		
3	Heart Disorder or Disease			17	Stomach Disorders		
4	Episodes of Passing Out			18	Diarrhea		
5	Bleeding Disorders			19	Constipation		
6	Blood Disorders			20	Abnormal Menstrual Cycles		
7	Hepatitis A,B, or C			21	Problems with Joints		
8	Diabetes			22	Chronic or Recurrent Illnesses		
9	Skin Problems (rashes, itching)			23	Past or Recent Surgeries		
10	Skin Breakdown (bed sores)			24	Past or Recent Hospitalizations		
11	Eating Disorder			25	Problems Sleeping		
12	Emotional Difficulty (for which professional help was sought)			26	Adaptive Equipment (braces, wheelchair, walker, hearing aid, C-PAP)		
13	Brain Injury			27	Self-Injurious Behavior:		
14	Chicken Pox			28	Other:		

Please explain any “yes” answers from above. List the number before explanation.

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.

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?_____

_____

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

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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, 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:

_____Diptheria, Pertussis & Tetanus (DPT)

_____Diptheria & 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

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

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.

Medical Need:	**To Be Treated With:**
Abrasions, Scratches, Lacerations (minor)	Apply Triple Antibiotic Ointment
Allergic Reaction: Severe reaction with symptoms of difficulty breathing, cyanosis, shock, hives, itching. OR Campers with known allergy.	Epinephrine, EpiPen
Allergic Reaction: Mild, NO Respiratory Symptoms	Benadryl, Hydrocortisone Cream
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	Sting Ease
Cold Symptoms, Runny Nose, Cough, Allergies, Nasal Congestion	Sudafed Cold & Allergy, For Environmental Allergies: Loratadine
Constipation	Dulcolax or Bisacodyl Tabs, Dulcolax Suppository, Fleets Enema, Glycerin Suppository, Milk of Magnesia
Cough	Robitussin (guaifenesin)
Cramps: Menstrual or Muscle	Ibuprofen
Diaper Rash	Bordeaux's Butt Paste
Diarrhea	Antidiarrheal Caplets or Immodium
Ear Aches	Tylenol
Eye Irritation– Minor	Normal Saline (eye drops) or Visine (eye drops)
Fever –Greater that 100° F	Acetaminophen: 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)	OTC Antifungal Cream

Headaches	Aceteminophen, Ibuprofen
Heartburn/Acid Indigestion/Sour Stomach	Tums/Rolaids, Mylanta/Maalox, Zantac 75
Hemorrhoids	Anusol Cream, Preparation H Suppositories
Hypoglycemia	Glucose tabs or instant Glucose Gel: **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	Benedryl Cream, insect repellant
Lice	Nix, RID, Clear, R&C Lice Control
Mouth Sores	Blistex or Camphophenique
Muscle Strains/Arthritis	Absorbine Jr. Apply topically TID pm, Myoflex or Analgesic Balm
Nausea/Vomiting	Maalox Mylanta, Pepto Bismol
Poisoning	Call Poison Control Center– 1-800-222-1222
Rash	Caladryl Cream, Calamine Lotion/Spray, Hydrocortisone Cream 1%
Restlessness/Insomnia	Benadryl
Sore Throat	Warm Salt Water, Throat Lozenges, Chloraseptic Spray
Sun Protection	Sun screen
Vaginal Itching	Vagisil Cream

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

_____ _____

Physician's Signature (Required) **Date**

_____ _____

Parent / Guardian Signature **Date**