United Cerebral Palsy's

CAMP SMILE

There's No Limit To The ADVENTURE

Office Use Only
Date Rec: _____ Conf Sent: _____
Reg. Pd: _____ Paid by: _____

2017 Weekend Respite Camp
November 3-5, 2017

Campers are to arrive Nov. 3 @ 5:30 pm and be picked up Nov. 5 @ 9:30 am.

ATTACH A CURRENT PHOTO HERE

(Only necessary if this is your first time attending Camp SMILE)

2017 WEEKEND RESPITE CAMP

Send application and $50 registration fee to:
UCP of Mobile/Camp SMILE
3058 Dauphin Square Connector
Mobile, AL 36607

Eligibility Requirements for Weekend Respite Camp:

1. Applicant must be between the ages of 13 and 25.
2. Applicant must have a moderate physical, mental or health care need
3. Applicant must live at home and receive direct primary care from a family member.
4. Applications must be received no later than October 16, 2017.
5. A $50 registration fee must accompany the application.

*******************IDENTIFYING INFORMATION PLEASE PRINT OR TYPE**************************

Camper's Last Name	Camper's First Name	Age	Sex	**Date of Birth**	Parent's Email Address

Camper's Address	City	St	Zip	County

Custody Status: ___Lives with mother ____Lives with father ____Lives with both parents ___Lives with other family member (Please specify: _____)

Legal Guardian's Full Name	Address	City	ST	Zip	Home# Cell# Work#

Emergency Contact Name	Address	City	ST	Zip	Home# Cell# Work#

INSURANCE INFORMATION

Medicare or Medicaid #_____
(circle one)

Primary Insurance: _____Policy #: _____

Name of Insured: _____ Group #: _____

Family Doctor's Name: _____ Dr's Office #: _____

Hospital Choice: _____

<u>TRANSPORTATION:</u> CAMPERS ARE RESPONSIBLE FOR THEIR OWN TRANSPORTATION
Directions to Camp Grace will be mailed with your acceptance letter.

DEADLINE FOR APPLICATION IS OCTOBER 16, 2017

Camper Name: _____ Height: _____ Weight: _____

Nature of Disability (please check all that apply):

____ Arthritis ____Asthma ____ Autism/PDD ____Attention Deficit Disorder ____ADHD ____ Cerebral Palsy (walks) ____Cerebral Palsy (wheelchair)
____COPD ____Diabetes ____ Down's Syndrome ____ Hearing Impaired ____Heart condition ____Hydrocephaly ____Hypertension ___ Learning Disability
____ Muscular Dystrophy ____ Seizure Disorder ____ Spina Bifida ____Traumatic Brain Injury ____Visually Impaired ____Other:_____
____ Intellectual Disability (specify level): ____Mild ____Moderate ____Severe ____Profound
Does camper have a shunt? _____YES _____NO

Past Medical History

If camper is subject to seizures, please describe type, length, frequency and treatment:

_____

Date of last seizure: _____ When do seizures most likely occur? _____
Camper Immunization's up-to-date? ____ Yes ____ No Date of last Tetanus shot: _____

*Please attach a copy of camper's current immunization card. If you turned in proof of immunization this summer, there is no need to attach document again.

Can Camper take Tylenol: ____Yes ____ No Can Camper take Ibuprofen? ____Yes ____No
Any major illness or hospitalizations in the last year? ____ Yes ____ No If yes, please describe:

_____

***If camper has been hospitalized within the last 3 months, a doctor's release is required to attend camp.**

List ALL DRUG ALLERGIES, indicating reaction & action to be taken afterward:

_____

MEDICATIONS: **Please list all medications, purpose and dosages of each medication, and times each should be taken.**

Name of medication	**Purpose of medication**	**Dosage**	**Times to be taken**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>List any other medications on a separate sheet of paper and attach with this application.</u>

Please give specific instructions as to how medication is given. (ie: crushed in yogurt) IF MEDICATIONS ARE GIVEN WITH ANYTHING BUT WATER, YOU MUST SEND IT WITH CAMPER TO CAMP (ie: peanut butter, yogurt, juice).

_____

THE CAMP NURSE DISPENSES MEDICATION ON THE FOLLOWING SCHEDULE: 7;30am, 12;00 noon, 5;30pm and 8:30pm. IF IT IS IMPOSSIBLE TO ADJUST THE CAMPERS MEDICATION TO THIS SCHEDULE, PLEASE INDICATE THE SCHEDULE SHE/HE MUST ADHERE TO: _____

_____

*** Please note: Campers are expected to bring sufficient supplies of their medication(s), properly identified, with complete directions for usage. Send enough for the camper's entire stay plus several extras. Remaining medication will be returned. Please do not send the ENTIRE prescription. <u>ALL medications must be sent in current prescription bottles. Over-the-counter medications must be in original containers.</u>**

PERSONAL HISTORY

Must be completed by parent/guardian or adult applicant.

Name of camper's school, rehabilitation program or employer: _____

Is this the camper's first time being away from home overnight? ____Yes ____No

Indicate required assistance or level of involvement with the following:

MEALTIME:

Eating: ____ No assist ____ Partial assist ____ Total assist

Diet: ____ Normal ____ Chopped ____ Blended/Pureed ____Tube-fed

____Diabetic ____ Gluten free ____ Casein free ____ Lactose intolerant ____ Other

If camper is diabetic, does camper require a bedtime snack? ____Yes____ No

If camper is diabetic, please indicate _____#of calories/day or ____#carbohydrates/meal

If camper is tube-fed, please list feeding schedule, type of formula used and amount fed at each feeding:

_____

List special plates, spoons, dentures, etc: _____

If diet limitations are severe, please list <u>extensive</u> meal options on a separate sheet

List ALL FOOD ALLERGIES, indicating reaction & action to be taken afterward**:** _____

_____

VISION:

____ Normal ____ Partial ____ Legally Blind ____ Total Vision Loss

Camper wears (check all that apply): ____ Glasses____ Contacts Please describe: _____

HEARING:

____ Normal ____Mild loss ____ Moderate loss ____ Severe loss ____ Total loss

____ Hearing aid (Make & Model) _____

COMMUNICATION:

____ Non-verbal ____ Few words ____ Normal ____ Sign Language ____ Gestures ____ Communication board/device

Will camper be bringing device: ___Yes ___No Other: _____

*If camper is non-verbal, please give helpful hints for communicating: _____

_____

MOBILITY:

____ Walks independently ____ Walks with frequent falls ____ Walks using canes ____ Walks using walker

____ Uses manual wheelchair ____Uses power wheelchair

Can the camper <u>independently</u> use his/her wheelchair? ____Yes ____No

List any other mobility needs or devices. Be sure to describe and tell when they are worn:

_____

List make & model of any equipment: _____

TOILETING:

____ No assistance ____ Partial Assistance ____ Total Assistance

Bladder Control: ____ Normal ____ Partial ____ Incontinent ____ Needs Reminders

Bowel Control: ____ Normal ____Partial ____ Incontinent ____ Needs Reminders

Aids used (check all that apply): ____ None ____ Urinal ____ Catheter Type: _____

____ Adaptive toilet chair ____ Diapers ____Diapers (night only) ____ Colostomy ____ Urostomy ____ Ileostomy

____MACE ____Other: _____

Please list toileting aid schedule: _____

PERSONAL HISTORY continued

Indicate required assistance or level of involvement with the following:

WASHING/BATHING:

____ No assistance ____ Partial Assistance ____ Total Assistance

Prefers: ____Shower ____Tub Bath ____ Sponge Bath

DRESSING:

____ No assistance ____ Partial Assistance ____ Total Assistance

SLEEPING:

Camper usually sleeps on: (side, back, etc…)_____ Can camper sleep on top bunk? ____ Yes ____No

Please check all sleeping habits that apply:

____Light sleeper ____Sound sleeper ____ Needs to be turned during the night ____Requires bedrails ____May wet the bed ____

____May have difficulty sleeping ____May wander during the night ____Takes medicine to help he/she sleep

Please list night time rituals or anything we may need to know to make bedtime successful: _____

_____

BEHAVIOR:

Please check all behavior concerns that apply:

____No real behavior concerns ____Sensitivity to sound or other stimuli ____May be homesick ____May be stubborn ____May not mix well with groups

____May eat non-edible objects ____May have tantrums ____May hurt him/herself when upset ____May be aggressive toward others when upset

____May make self sick or vomit ____May use foul language ____May run off ____Other: _____

*If camper is sensitive to stimuli, please describe: _____

Please check behavior modification techniques used at home/school:

____No behavior management techniques used ____Positive reinforcement ____Redirection ____Ignoring ____Remove from situation ___Time out

____Picture/written schedule ____Other: _____*Please list reinforcers that work at home: _____

CAMP ACTIVITIES:

Swimming: (Check all that apply)

____Loves the water ____Afraid of the water ____Swims well ____Has limited swimming skills ____Does not know how to swim

____May not swim in LAKE water ____Has tubes in ears *Please list any special instructions for swim time: _____

Horseback Riding: (Check all that apply)

___Loves horses ____Afraid of horses ____Rides well ____Has limited riding skills ____Has never ridden before ____I do not want camper to ride

*please list any special instruction for horseback riding: _____

REGISTRATION INFORMATION:

A **$50** registration fee is required for each camper. This fee should be sent in with completed application no later than October 16, 2017. Applications will not be processed without the registration fee.

Slots will be limited to 25 females and 25 males. Acceptance will be given on a first come, first serve basis based on eligibility requirements and need.

BECAUSE THE NUMBER OF CAMPERS WE CAN ACCEPT IS LIMITED, WE ASK THAT YOU PLEASE NOTIFY US AS SOON AS POSSIBLE IF YOUR CHILD CANNOT ATTEND SO THAT WE MAY ALLOW SOMEONE ELSE THE OPPORTUNITY TO TAKE ADVANTAGE OF THIS MUCH NEEDED RESPITE.

REFUND POLICY:

All fees will be refunded when notification of cancellation is received in writing **ten (10) days** prior to the beginning of the camp session that camper has applied for.

I hereby apply for enrollment of my child in Camp SMILE Weekend Respite Camp provided by United Cerebral Palsy of Mobile, Inc. As a condition of such enrollment, I hereby represent to United Cerebral Palsy of Mobile, Inc. on behalf of myself and my child, my agreement with the general terms and conditions as follows:

_____ (initial) **Understanding of Risks**: I am aware that some camp activities, whether it be swimming, horseback riding, or any other associated activities, involve inherent risks and dangers to the participant, including serious injury or death.

_____ (initial) **Release of Liability**: I release United Cerebral Palsy of Mobile, Inc., property owners, their owners, agents, employees, successors of assigns, lessors and joint ventures from any and all liability, claims, demands, actions, causes of action, expenses and damages in any way resulting from personal injuries, conscious suffering, death or property damage sustained by my child or others arising out of my child's participation in camp activities. I hereby expressly waive all claims that I may have against UNITED CEREBRAL PALSY OF MOBILE INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES for each and all the foregoing.

_____ (initial) **Indemnity**: My child will exert every effort to follow the rules and instruction he/she has received prior to or during camp activities. I hereby agree for my child, myself, my heirs, personal representatives and assigns to indemnify, defend and hold harmless UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES from and against any and all losses, claims, demands, actions or proceedings of any kind which may be initiated against any of the foregoing by any person and arising out of any action or inaction on my part or the part of United Cerebral Palsy of Mobile, Inc., or its owners, agents, employees, successors or assigns and in any way related to any of the activities described in the preceding paragraph or contemplated under this agreement.

_____ (initial) **Continuation of Terms**: I agree and acknowledge that the terms and conditions of this Agreement, including my assumption of risk (paragraph 1), release of liability (paragraph 2), and indemnity (paragraph 3) shall continue in full force and effect at all times during which my child is engaged as a participant at Camp, shall continue in full force and effect for the benefit of UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR THE BUSINESS LAND OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES at all times after the termination of the activities contemplated by this agreement and shall be binding upon my heirs, personal representatives and the assigns of my estate.

_____ (initial) **Disputes**: This agreement shall be interpreted in accordance with the laws of the State of Alabama. Any dispute shall be litigated in Mobile County Alabama.

_____ (initial) **Medical Release**: I hereby grant to the Camp Physician or his authorized representatives permission to furnish or arrange the furnishing of such hospital and medical care as named above camper MIGHT REQUIRE DURING SUCH TIME AS HE/SHE IS A CAMPER AT CAMP SMILE. This medical care shall include, but not be limited to, examinations, treatment, immunizations, injections, anesthesia, surgery and other procedures, etc. I understand that I shall be notified as soon as possible. Failure in such efforts shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of said camper.

_____ (initial) **Media Release**: I further grant permission for above named camper to be photographed, with such pictures and names to be used in public relations and fund raising efforts to promote programs of Camp Smile.

I AM THE PARENT OR LEGAL GUARDIAN OF THE PARTICPANT, _____. I HAVE READ AND UNDERSTAND ALL OF THE TERMS OF THIS AGREEMENT, INCLUDING THE "GENERAL TERMS" ABOVE. TO INDUCE UNITED CEREBRAL PALSY OF MOBILE INC. TO ENROLL THE PARTICIPANT IN CAMP AND TO ALLOW HIM/HER TO PARTICIPATE IN ALL CAMP ACTIVITIES. I AGREE ON BEHALF OF THE PARTICIPANT AND MYSELF TO BE BOUND BY THE GENERAL TERMS OF THIS AGREEMENT AND NOT TO CLAIM NOT TO BE BOUND BY THIS AGREEMENT BY REASON OF MY CHILD'S MINORITY STATUS OR OTHERWISE, I HEREBY AGREE TO INDEMNITY, DEFEND AND HOLD HARMLESS UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEY, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES FROM AND AGAINST ANY AND ALL LIABILITY OR LOSSES RESULTING FROM ANY SUIT AGAINST UNITED CEREBRAL PALSY OF MOBILE, INC. BY THE PARTICIPANT OR OTHERWISE RESULTING FROM A BREACH OF AGREEMENT.

_____ _____

Date Parent/Guardian

_____ _____

Date Witness