

DAY CAMP Health Form and Waiver Instructions

We thank you for your support. The following form to be completed:

Name of Participant _____

Nickname _____ o Female o Male

Date Of Birth: _____ Age as of June 13: _____ Grade entering in fall: _____

Home address _____

Street address City / State / Zip Summer address

Phone(s): H: _____ W: _____ C: _____

E-mail _____ (Needed for camp communication)

Parent or guardian _____ Relationship _____

Insurance Information ♦ Must be completed.

This Camper is not covered by health and accident insurance or Medicaid.

Insurance carrier or Plan Name _____

Insurance ID # _____

Name of insured _____

Relationship to participant _____

Health Care Provider Name _____

Phone _____

Name of provider's practice _____

Address _____

DAY CAMP Health Form, Medical Waiver and Release 2016

- 1) List what the Camper is allergic to: _____
- 2) The reaction seen _____
- 3) How to manage the reaction _____
- 4) Medications are to be brought to camp, you must complete MEDICATION SECTION.
- 5) History—If your Camper has any special conditions, needs or limitations, you must speak with the Program Director prior to being accepted into the program. Non-disclosure may result in dismissal from the program with no refund.

Has/does the participant: Y N

- | | |
|--|---------|
| 6) Ever been stung by a bee?..... | 0.....0 |
| 7) Have frequent stomachaches? | 0.....0 |
| 8) Have problems with constipation/diarrhea?..... | 0.....0 |
| 9) Ever been treated for an eating disorder?..... | 0.....0 |
| 10) Passed out/had chest pain during or after exercise?.. | 0.....0 |
| 11) Have problems with falling asleep or sleepwalking?..... | 0.....0 |
| 12) Have a current history of bed-wetting?..... | 0.....0 |
| 13) If female and of appropriate age, have problems with periods/menstration?..... | 0.....0 |
| 14) Have frequent bloody nose?..... | 0.....0 |
| 15) Ever been treated for emotional or behavioral difficulties?..... | 0.....0 |
| 16) Ever been treated for ADD or ADHD? | 0.....0 |
| 17) Currently on an IEP (individualized education plan)?.... | 0.....0 |
| 18) Ever have need for an aide at school? | 0.....0 |

Explain any “yes” answers, noting the number of the question.

To better serve your Camper, please share any information about his/her behavior, physical, emotional or mental health about which we should be aware. These may include shyness, socialization difficulties, issues with stress, learning style, etc. Please list strategies used to manage the concern and/or to enhance your Camper's ability to be more successful and happier while with us. When your Camper is upset, how do you calm him/her down?
 Activity Restrictions—Please inform us of any restrictions that might limit your Camper's participation. In addition you must speak with the Program Director regarding the issue.

MEDICATION SECTION

At-Home Medications—

Please list the condition and medications taken at home (Example: Hay fever-Claritin). Any medications to be taken during the hours of the program must be listed.

No medications taken on a routine basis.

Taken Daily: _____

Taken Seasonally: _____

As needed: _____

Has/does the participant: Y N

- | | |
|---|---------|
| 1. Had a recent injury, illness or infectious disease?..... | 0.....0 |
| 2. Have a chronic or recurring illness/condition?..... | 0.....0 |
| 3. Had diabetes or problems with blood sugar control?... | 0.....0 |
| 4. Been hospitalized/surgery within past 2 years?..... | 0.....0 |
| 5. Have frequent headaches?..... | 0.....0 |
| 6. Ever had a head injury?..... | 0.....0 |
| 7. Had a seizure?..... | 0.....0 |
| 8. Wear eyeglasses, contacts or protective eye wear?..... | 0.....0 |
| 9. Traveled outside of the country in the past 9 months?... | 0.....0 |
| 10. Had fainting or dizziness? | 0.....0 |
| 11. Had asthma/wheezing? Note type and severity below..... | 0.....0 |
| 12. Have any skin problems (rashes, severe acne)?..... | 0.....0 |
| 13. Had mononucleosis in the past 12 months?..... | 0.....0 |
| 14. Ever been treated for Lyme Disease?..... | 0.....0 |
| 15. Have motion sickness? | 0.....0 |

Name of Camper: _____

Dietary Restrictions *Peanuts/Nuts: Due to the public nature of our site we cannot guarantee that any area is peanut/nut free.

Check all restrictions that apply.

Kosher Vegetarian No Dairy No Eggs No Peanuts* No Tree Nuts* Reason for the restriction/s: _____

Name of Camper: _____ Age: _____ Weight: _____

MEDICATION SECTION (Cont'd)

At-Camp Medications

◆ List any medications that MAY have to be administered during camp hours on a regular or as needed basis. ◆ Parent/Legal Guardian must supply any and all medications. ◆ Expired medications will not be allowed at the program site. ◆ By completing this section and signing the waiver you will be authorizing the medications listed to be administered by staff, as directed, to the person for whom it was prescribed. ◆ All medications must be approved by off-site healthcare consultant/physician; seen and checked by the health supervisor; and staff must monitor each dose. Requires a signature by your healthcare provider, see the box below.

* Prescription medications must be in their original containers bearing the pharmacy label and have specific instructions for use (Camper's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

#1 _____ Amount/dose given _____

Time/when it is given _____ Reason for taking _____

How it is given: _____ o Inhaled o By mouth o Other: _____

#2 _____ Amount/dose given _____

Time/when it is given _____ Reason for taking _____

How it is given: _____ o Inhaled o By mouth o Other: _____

#3 _____ Amount/dose given _____

Time/when it is given _____ Reason for taking _____

How it is given: _____ o Inhaled o By mouth o Other: _____

Over-the-counter medications must be in their original containers containing the original label and directions for use. In addition these must be labeled with the participant's name and dose. You must supply any medication.

#1 _____ Amount/dose given _____

Time/when it is given _____ Reason for taking _____

How it is given: _____ o Inhaled o By mouth o Other: _____

#2 _____ Amount/dose given _____

Time/when it is given _____ Reason for taking _____

How it is given: _____ o Inhaled o By mouth o Other: _____

MEDICATION SECTION (Cont'd)

Asthma—

- 1) List each medication separately above.
- 2) The pharmacy label must accompany each med.
- 3) Sign the relevant statement below.

• My Camper does not need to have the inhaler with him/her at all times. The medication may be stored in the medication box (MB) in the office.

Parent/Legal Guardian's Signature _____

• My Camper should have the medication/s with him/her at all times in the camp pack (P). Note: Our staff must monitor each dose.

Parent/Legal Guardian's Signature _____

• My Camper will bring a: nebulizer spacer

Allergy—

- 1) List each medication separately above.
- 2) The pharmacy label must accompany the med.
- 3) Sign the relevant statement below.
- 4) Two Epipens should be provided.
- 5) Your Camper must be trained in the use of the EpiPen.

• My Camper does not need to have the medication/s with him/her at all times. The medication may be stored in the medication box (MB) in the office. Circle which medication/s: Benadryl, EpiPen

Parent/Legal Guardian's Signature _____

• My Camper should have the medication/s with him/her at all times in the camp pack (P). Note: Camp staff must monitor each dose. Circle which medication/s: Benadryl, EpiPen
Parent/Legal Guardian's Signature _____

• If an EpiPen is prescribed, does the Camper recognize the onset of an allergic reaction so as to notify staff upon the occurrence of these symptoms? Yes No
If no, contact the office today.

Signature: _____ Date: _____

Name of Camper: _____

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Release / Pick Up Name of Camper: _____

- • • In case of a request for the release of the child to a person not listed below, the child will remain with staff until you have been contacted and have given us permission to release him/her.
- • • Pick up people need to bring a photo ID.
- • • To make additions to this list, the guardian may send a signed note.
- • • If there are specific people your child may not be released to, as an extra precaution, please inform the camp in writing.
- • • Give first and last names (John/Susan Lee, not “the Lees”). Specify if phone numbers are cellular or pagers.

My child may be released to the following people (include carpool drivers and those to pick up in an emergency):

1. Name: _____ Relationship: 1st Parent/Guardian
Phone (Day) _____ (Eve) _____ (Cell) _____
2. Name: _____ Relationship: 2nd Parent/Guardian
Phone (Day) _____ (Eve) _____ (Cell) _____
3. Name: _____ Relationship: _____
Phone (Day) _____ (Eve) _____ (Cell) _____

Medical Waiver and Authorization • Agreement to these terms is a required for participation.

- 1) Medical release: This Health History is correct and complete as far as I know. I hereby give permission to staff to provide routine healthcare, administer prescribed and over-the-counter medications as described, and seek emergency medical treatment for me. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to staff to arrange necessary related transportation for myself. In case of a medical emergency, every reasonable effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission for the medical personnel selected by designated healthcare staff to secure and administer medical treatment including to hospitalize, order and administer medications and anesthesia, perform X-rays, special procedures, or surgery, if deemed medically necessary for my child named above, for which charges I shall be responsible and agree to pay.
- 2) Medications: I authorize the “At-Camp Medications” listed above to be administered by designated healthcare staff, as directed, to my child for whom it was prescribed. I understand that all medications, prescribed and over-the-counter, must be in their original containers and be labeled with specific instructions, including the person's name and dosage, and that the pharmacy label must be on all prescribed medications.
- 3) Insurance: I certify that the participant herein described is covered by health and accident insurance or Medicaid and that the policy information given on page 1 is correct. Note: A copy of the child's insurance card must be given.
- 4) Release/Pick Up: I understand the Release Policy as described in the Information Packet and authorize Staff to release my child to the persons and/or method listed above. I, the parent/legal guardian of the participant, have read, understood, and agree to the above.

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Parent/Legal Guardian's Signature / Printed Name / Date

Audio/Visual Image Release

Tackling the Streets uses images and sounds of children and staff participating in programs as a way of documenting the enjoyable and educational experiences they have. Tackling the Streets will not identify my child, or will identify my child only by first name and program, unless I give specific written permission to do otherwise. In consideration of the above, I hereby consent to Tackling the Streets:

- (1) photographing, filming, and video/audio taping my child, and
- (2) using and displaying images and sounds of my child in Tackling the Streets' websites, archives, and promotional or informational material, including, but not limited to, newsletters, brochures, advertisements, and newspaper articles, and I hereby waive and release on behalf of my child any rights of compensation for, or ownership of, such images and/or sounds of my child.
- (3) I further give permission and consent that any such images and sounds may be published and used to illustrate and promote the camp experience. I have read this media release and agree to its terms and conditions.

Parent/Legal Guardian's Signature / Printed Name / Date

Name of Camper: _____

Acknowledgement of Risk and Assumption of Personal Responsibility

Staff members make every effort to conduct safe programs, to orient and support children, and to inform families of inherent risks. Some activities may involve risks that children do not routinely encounter at home. Risk management is an essential element of all the activities that we offer. While we anticipate that these efforts will ensure the wellbeing of each child, we are also aware that it is neither possible to foresee every contingency nor to eliminate all risk. I understand that other risks may be inherent in program activities. I acknowledge that such risks exist, and I hereby agree on behalf of my child to assume such risks. Further, on behalf of my child, I hereby release and forever discharge, and agree not to sue, and agree to indemnify and hold harmless, Tackling the Streets Staff and its officers, directors, employees and volunteers and each of them, from and against any and all liabilities and obligations of every kind and description, which I shall or may have against them or any one or more of them arising out of, or in connection with, my child's participation in the program and its activities, including, but not limited to, for any personal injury that my child may suffer while participating in the program and its activities, excepting in the case of gross negligence. I understand and agree on behalf of my child that my child shares the responsibility for safety during program activities, and I personally assume on behalf of my child that responsibility. I understand and certify that my child's participation in the program and its activities is completely voluntary, and that I have become familiar with the program activities in which my child may participate as described in the Agreement of Terms, newsletter, camp brochure or information packet.

Parent/Legal Guardian's Signature / Printed Name / Date

Name of Camper: _____