Thank you for your interest in CampAbility which will be located at Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240. We are excited that you and your family are considering sending your loved one to spend time with us this summer!

CampAbility is a traditional, non-academic, day camp designed to serve families of children who present with a primary disability such as cerebral palsy, spina bifida, down syndrome, autism, developmental delays, etc. Should you have questions regarding eligibility for this camp, please contact us.

Below you will find a list of the registration forms (mandatory and supplemental) that must be completed in order for your child to attend CampAbility. These forms must be thoroughly completed and submitted with all supporting documents and the camp deposit in order to secure a spot for camp. Your spot will not be confirmed until we have all necessary documents and information. Registration forms are due April 28, 2017

We have a lot of fun activities planned including field trips, therapeutic horseback riding, special guest visitors and much, much more! We can’t wait to hear from you! 😊

☐ **MANDATORY FORMS:**
- 2017 CampAbility Registration Form ................................................................. 2-5
- Reservation and Payment Information ................................................................. 6
- Authorization to use Likeness or Information ........................................................... 7
- Morning Dove Horseback Riding Forms ............................................................... 8-13

☐ **SUPPLEMENTAL FORMS:**
- Physician’s Medication Administration Form (requires doctor signature) .............. 14
- Scholarship Application Form ............................................................................... 15
- Before and After Care Form ............................................................................. 16
- Special Preparation & Food Allergy Plan ............................................................. 17-18
- Seizure Action Plan ............................................................................................ 19-20
- G-Tube Action Plan ........................................................................................... 21-22

**FREQUENTLY ASKED QUESTIONS** ........................................................................... 23

For questions regarding camp or to submit payment and registration forms, please contact:

**Easterseals Crossroads, Attn: Karen Kelley**
4740 Kingsway Drive
Indianapolis, IN 46205

Phone: 317.466.1000 | Fax: 317.466.2000 | Email: kkelley@eastersealscrossroads.org
2017 Annual Registration Forms

Directions: Page 2 should be completed once for your family and pages 3-5 for each participant.

Parent/Guardian/Caregiver Information:
Name: ____________________________________
Address:___________________________________
City: ________________ State: ______ Zip: _____
Home: ________________ Cell: _______________
Email address: __________________________________

Individuals Attending Respite Programs:
Name: ________________________   Age:_______ Name: ____ _________________   Age:_____
Name: ________________________   Age:_______ Name: __________ ___________   Age:_____
Name: ________________________   Age:_______ Name: __________ ___________   Age:_____
Name: ________________________   Age:_______ Name: __________ ___________   Age:_____

By signing below, I acknowledge the following: I have provided Easterseals Crossroads with the most recent and up-to-date information including health, medical and authorized pick up user information for the above listed participant(s). In addition, I have attached all of the required support plans in order to ensure participants have a safe and healthy experience while participating in the Respite events. I understand if the individual’s behavior poses a threat to his safety or the safety of others, the individual may need to be withdrawn from the program. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified above for the participant.

Parent/Guardian Signature: ___________________________________________ Date: __________

EMERGENCY CONTACT INFORMATION (other than parent/caregiver listed above):

1. Name: ____________________________________ Relation to participant: _______________
   Home Number: _________________________ Cell Phone Number: _______________________

2. Name: ____________________________________ Relation to participant: _______________
   Home Number: _________________________ Cell Phone Number: _______________________

Preferred Hospital: _________________________ Preferred Doctor: _______________________
Address: __________________________________ Phone: _________________________
Participant Information

Name: __________________________________ Date of Birth:________________

Primary Disability: __________________________ Secondary Disability: __________________________

Allergies (meds/food): ________________________________________________________________

School Classroom Setting (i.e. general education, special education, ABA center etc.): __________________________

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.) ☐ yes ☐ no

If yes, please explain______________________________________________________________

Ethnicity:
☐ African American ☐ Native American ☐ Asian American ☐ Caucasian
☐ Hispanic ☐ Multiple Ethnicities ☐ Other: __________________________

Support plans:
My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

☐ Individualized Education Plan ☐ Behavior Support Plan ☐ Individual Support Plan
☐ Seizure Management Plan ☐ Other: _____________ ☐ Not Applicable; Reason: __________

Levels of Care:
Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

Toileting
☐ Participant is fully independent

If not, please circle which of the following are applicable:

- Reminders
- Assistance with clothing
- Assistance after a bowel movement
- Assistance with washing hands
- Assistance transferring on/off toilet

Please describe: ________________________________________________________________

Ambulation/Risk of Falling (Seizures)
☐ Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

- Use of wheelchair
- Use of prosthetics/orthotics
- Requires assistance ambulating/transferring
- Risk of falling due to instability
- Risk of falling due to seizures
- Other: __________________________

Please describe: ________________________________________________________________

Medication Administration
☐ Participant will frequently require medication administration while at Respite events

(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)

☐ Participant will not require medication administration while at Respite events
☐ Participant requires administration of **PRN medication** (i.e. inhaler, melatonin, diastat, epi-pen)

**Please describe:** ____________________________________________

**Level of Supervision Needed**
☐ Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision
☐ Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants
☐ Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants
☐ One-on-One – participant requires an adult by their side at all times in order to remain engaged

**How does your child respond to new environments?:** ________________________________

**Leisure Activities**

**Please circle activities that your child enjoys participating in:**
- Outside/Playground
- Video games/electronics
- Gym
- Arts/Crafts
- Movies
- Painting/Coloring
- Sports
- Pretend Play
- Board Games
- Reading Books
- Music/Dancing
- Other: ________________

**Please describe:** ____________________________________________

**Nutrition/Feeding**

☐ Participant is fully independent

**If not, please circle which of the following are applicable:**
- Special preparation of food (i.e. pureed, soft, cut into small pieces, etc)
- Food allergies
- Diabetic
- G-tube feedings
- Diet restrictions
- Bottle feeding
- Choking risk
- Assistance opening packages
- Assistance with feeding/using utensils
- Picky eater (please list preferred foods below)
- Snack will be provided by parent/caregiver

**Please describe:** ____________________________________________

______________________________________________________________________
Communication

☐ Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

- Requests items by pointing
- Sign/Gestures/ASL
- Communication device
- Vocalizations/sounds

Please describe: ____________________________________________________________
________________________________________________________________________

Sensory

Please indicate by circling which of the following may impact the participant’s behavior/participation:

- Bright lights/Sunlight
- Hot/Cold
- Touch
- Sounds/Loud noises
- Animals
- Thunderstorms
- Other: __________________________

The participant enjoys the following sensory activities:

- Ear protection
- Chewy toys
- Weighted blankets/vests
- Light-up objects
- Water play
- Deep pressure hugs/massage
- Body brushing
- Fuzzy toys
- Other: _________________________

Please describe: __________________________________________________________
________________________________________________________________________

Behaviors

Directions: Please indicate the approximate frequency (if at all) of the following behaviors.

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>COUNT</th>
<th>TIME</th>
<th>DIRECTION GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Does not comply with requests</td>
<td>3 times</td>
<td>per hour</td>
<td></td>
</tr>
<tr>
<td>Scratches, pinches, bites, or hits self</td>
<td>per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scratches, pinches, bites, or spits on others</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangs head</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grabs others</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulls Hair</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runs away/risk of elopement</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets into/takes others personal belongings</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strips down clothing/exposes self in public</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reservation and Payment Information

Participant Name: ___________________________         Date:_______________

Cost: CampAbility costs $300 per session ($199 early bird special if registration is received between January 16th and February 28th 2017.

To reserve a spot at CampAbility you must include the following:

- A $100 deposit per camp session (the deposit is refundable if cancellation occurs two weeks or more prior to the session start date).
- All completed registration forms with doctors signatures (where needed)
- Support plans

Please indicate below which camp you would like the participant to attend and which sessions:

☐ CampAbility - Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240 (Ages 4-10)
  ☐ Session 1: June 12 – June 22 (Mondays – Thursday)
  ☐ Session 2: June 26 – July 7 *PLEASE NOTE: THE 1st WEEK OF SESSION 2 WILL RUN M-F AND THE 2ND WEEK WILL RUN WEDNESDAY-FRIDAY DUE TO THE 4TH OF JULY
  ☐ Session 3: July 10 – July 20 (Mondays – Thursday)

Payment Information (please check one):

☐ CHECK (made payable to Easterseals Crossroads):
  I have enclosed a check in the amount of $ ______________ to cover the $100 deposit that is due for each session that we have indicated we’d like to attend.

☐ CREDIT/DEBIT:
  I authorize Easterseals Crossroads to charge my credit/debit card in the amount of $_______________ to cover the $100 deposit that is due for each session that we have indicated the above listed participant will attend.

Credit Card: ☐ Master Card ☐ Visa ☐ Discover Card ☐ American Express

Credit Card Number: ___________________________ Expiration Date: _______________

________________________________________  ____________________________
Cardholder’s Printed Name                 Cardholder’s Signature

Once we receive the completed registration forms and payment, we will send you a confirmation letter letting you know that your spot for camp has been reserved.
Authorization to use Likeness/Information

Consumer Name __________________________________ Date of Birth __________________

I, or my legal representative, understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Crossroads or its respective employees and agents may be used by Easterseals Crossroads and those acting with its permission for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Crossroads and that these materials may be released to the general public. I assign to Easterseals Crossroads all of my rights to these materials.

I understand that these materials made by Easterseals Crossroads, its employees and agents are owned by Easterseals Crossroads and that they may copyright them. I further consent to allow Easterseals Crossroads, their respective employees and agents, and those acting with Easterseals Crossroads’ permission to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Crossroads and to release this information to the general public.

I understand that these materials may be published by Easterseals Crossroads on the Internet. This may disclose my image, name and diagnosis, which is considered personal and protected health information. Easterseals Crossroads does not need to submit these materials to me for further approval and I further understand that Easterseals Crossroads may decide not to use these materials.

I acknowledge that the rights described above are granted to Easterseals Crossroads on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Crossroads will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Crossroads to release my protected health information, including image, name and diagnosis if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Crossroads in writing by sending my revocation to Easterseals Crossroads, Marketing Department, 4740 Kingsway Drive, Indianapolis, IN 46205.

I understand and agree that once Easterseals Crossroads, its respective employees and agents, and those acting with its permission disclose my protected health information, including image, name and diagnosis, as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires five years from the date of my signature below.

I have read this release and authorization before signing below, and I fully understand its contents.

___________________________________________________  _____________________
Signature of Consumer or Legal Representative    Date

___________________________________________________  ________________________________
Printed Name of Consumer or Legal Representative    Relationship to Consumer

____________________________________     ________________________
Witness         Date
PARTICIPANT RELEASE AGREEMENT

I, ________________________________________________, [OR, if participant is under 18 or not legally competent, then, I, the undersigned parent / parents and / or guardian / guardians on behalf of _______________________________________________ a minor] for and in consideration of the agreement with Morning Dove Therapeutic Riding Inc. to provide equine assisted activities to said participant, does / do hereby forever release, acquit, discharge and hold harmless Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said participant may now, or in the future, have against Morning Dove Therapeutic Riding Inc. its officers, trustees, agents, employees, representatives, successors and assigns, on account of any personal injuries, physical or mental condition, known or unknown, to the person of said participant and the treatment therefore as a result of, or in anyway growing out of, the acts or omissions of Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns, including their own negligent acts or omissions, in rendering the services above described or in anyway incidental thereto. The undersigned acknowledges that Morning Dove Therapeutic Riding, Inc. is an equestrian professional under Indiana Code 34-31-5 and is immune from liability for certain acts and omissions described in the statute. The following notice is provided according to the statute:

WARNING
UNDER INDIANA LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

In no way shall the immunity afforded in Indiana Code 34-31-5 limit the scope of this release.

I have read and understand this release.

DATE: __________________________________ SIGNED: ______________________________________________________

Print Name: __________________________________ (Participant or Parent/Guardian if under 18 or not legally competent)

WITNESSED: _____________________________________________

PHOTO RELEASE FORM

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant _____ does not grant _____ to Morning Dove Therapeutic Riding Inc. (MDTRC) permission to take or have taken, still and moving photographs and films including television pictures of _____________________________ and consents and authorizes MDTRC, its advertising agencies, news media, and any other persons interested in MDTRC, and its work, to the use and reproductions of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material. With regard to the foregoing material, no inducements or promises have been made to us / me to secure our / my signature(s) to this release other than the intention of MDTRC to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

I have read and understand this release.

DATE: ________________________       Signed ___________________________________________________________

(Participant or Parent/Guardian if under 18 or not legally competent)
PROPERTY OWNER RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

IN CONSIDERATION of being permitted to enter into property owned by Fortune Development, LLC and operated by Morning Dove Therapeutic Riding, Inc (hereinafter the “Farm”) for any purpose, including but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, the undersigned, for himself or herself and any personal representative, administrator, executor, heir, family member, successor and assign, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering will, inspect such premises and facilities. It is further warranted that such entry into the Farm for horseback riding, other equine activities, observation, participation or use of any facilities or equipment constitute an acknowledgement that such premises and all facilities and equipment thereon have been inspected and that the undersigned finds and accepts same as being safe and reasonably suited for the purposes of such observation or use.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE FARM FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, HORSEBACK RIDING, OTHER EQUINE ACTIVITIES, OBSERVATION, USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY WAY, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING.

1. THE UNDERSIGNED HEREBY ACKNOWLEDGES that horses may, without warning, kick, bite, balk, stomp, stumble, rear, bolt, fall down, and react to sudden movements, noise, light, vehicles, other animals or objects. Equestrian activities involve equipment that may break, fail or malfunction. Other riders may not control their animals, or ride within their ability, and cause a collision or other unpredictable consequences. Equestrian activities may be conducted in areas which are subject to constant change in condition according to weather, temperature, and natural and man-made changes in the landscape, including the riding ring, where objects are not marked and hazards may not be visible; where trails are not groomed, maintained or controlled; where weather is changeable, unpredictable and dangerous; and where lightning, thunder, beehives, streams, creeks, fallen timber, wild animals and other hazards and dangers exist.

2. THE UNDERSIGNED HEREBY RELEASES, WAIVES DISCHARGES AND COVENANTS NOT TO SUE EITHER FORTUNE DEVELOPMENT, LLC OR MORNING DOVE THERAPEUTIC RIDING, INC., its trustees, directors, officers, employees, and agents (hereinafter referred to as “releasees”) from all liability to the undersigned, his or her personal representatives, administrators, executors, heirs, family members, successors and assigns for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise while the undersigned is in, upon, or about the premises or any facilities or equipment therein. In the event that an attorney is engaged to enforce, construe, or defend any of the terms, conditions or claims or demands covered by this RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT, either with or without suit, the UNDERSIGNED agrees to pay all attorneys’ fees and costs incurred by the releasees.

3. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the Farm for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, whether caused by the negligence of the releasees or otherwise.

4. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of releasee or otherwise while in, about or upon the premises of the Farm and/or while using the premises for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way.
THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND
HOLD HARMLESS AGREEMENT is intended to be as broad and inclusive as is permitted by the law of
the State of Indiana and that if any portion thereof is held invalid, it is agreed that the balance shall,
notwithstanding, continue in full legal force and effect. THE UNDERSIGNED HAS READ AND
VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS
AGREEMENT, and further agrees that no oral representations, statements or inducement apart from the
foregoing written agreement have been made.

WARNING
Under Indiana Law, an equine professional is not liable for an injury to, or the death of, a
participant in equine activities resulting from the inherent risks of equine activities.

I HAVE READ THIS RELEASE (Rider/Guest 18 years of age or over):

Date _________________ Signature of Rider/Guest: ____________________________________
Print Rider/Guest’s Name: ______________________________________________________
Address: ______________________________________________________________________
Phone: ___________________ Email address: _________________________________________

I HAVE READ THIS RELEASE (Parent/Guardian if Rider/Guest is under 18 years of age or not
legally competent)

Date _______________ Signature of Parent/Guardian: __________________________________
Print Parent/Guardian Name: _____________________________________________________
Print Name of Rider/Guest: _______________________________________________________
Address: ______________________________________________________________________
Phone: ___________________ Email address: _________________________________________
MORNING DOVE THERAPEUTIC RIDING INC.

EMERGENCY RELEASE

Participant Name ___________________________ Parent/Guardian ___________________________

Physician’s Name ___________________________ Physician’s Phone ___________________________

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name ___________________________ Phone ___________________________ Relationship ___________

Name ___________________________ Phone ___________________________ Relationship ___________

Preferred Medical Facility: _______________________________________________________

Does this rider have a medical condition requiring special precautions or treatment including any medications and dosage: Yes/No ______ If yes, please describe _______________________________________________________

In case of medical emergency, the undersigned authorizes Morning Dove Therapeutic Riding Inc. to provide such medical assistance as they determine to be necessary.

The undersigned authorizes any licensed physician and / or medical facility to provide any medical / surgical care and / or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for program participation until this form has been completed by the parent / parents or guardian. If the person is of legal age (18), he or she may complete the form, if he or she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Morning Dove Therapeutic Riding Inc..

_____________________________________________ Date: _______________________

SIGNATURE OF PARENT / PARENTS OR GUARDIAN

_____________________________________________ Date: _______________________

SIGNATURE OF PARTICIPANT IF OVER AGE 18
PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: ___________________________ DOB: __________ Height: _______ Weight: _______

Address: ________________________________

Diagnosis: ______________________________ Date of Onset: __________ Past / Prospective

Surgeries: ________________________________

Medications: ______________________________

Seizure Type: _____________________________ Controlled: Y N

Date of Last Seizure: ______________________

Shunt Present: Y N Date of last revision: ________________________________

Special Precautions/Needs: ________________________________

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Spinal injury: Y N Point of injury: __________ Braces/Assistive Devices: ________________________________

Down Syndrome: Atlanto Dens Interval X-rays, date: __________ Results: + -

Neurological Symptoms of Atlanto Axial Instability: ________________________________

Please indicate current or past special needs in the following systems/areas, including surgeries:

<table>
<thead>
<tr>
<th>System</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tactile Sensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence (Other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary/Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8 |
Physician's Release Cont.

Which, if any of the following conditions are present?

___ Prior surgeries – physician release required post surgery
___ Planned surgeries – physician release required post surgery
___ Equipment/Medical Devices – participant cannot go without use of the equipment/medical device for 60 minutes OR the participant has indwelling urethral catheter
___ Condition which may require immediate medication
___ Condition which may be exacerbated by environmental factors (e.g., weather, presence of certain allergens)
___ Recent seizure activity
___ Active substance abuse

Explanation of any checked items above:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

General Observations or comments about this patient:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However I understand that the PATH International center will weigh the medical information above against the existence precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: ___________________________________________ MD DO NP PA Other
Signature: __________________________ Date __________________________
Address:______________________________________________________________
Phone:__________________________________________________________ License/UPIN Number_________________________
Physician’s Medication Administration Form

Participant’s Name ____________________________________________________________

Date of Birth ___________________________ Child’s Weight __________________________

**PRESCRIPTION MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)**

Camp staff have permission to give the above listed participant, __________________________, the following medication(s) ______________________________________________________________

Day(s)/Time(s) to be given ________________________________________________________

Dosage/Route ________________________________________________________________

Reason for medication __________________________________________________________

Should the medicine be taken with food or milk? __________ Yes __________ No

Any other special instructions? ___________________________________________________

_____________________________________________________________________________

**OVER-THE-COUNTER MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)**

Do you want camp and enrichment staff to administer over-the-counter medications when necessary and then according to recommended dosage for the child’s weight/age? __________ Yes __________ No

If yes, what medications will you provide for your child to take and for what purpose?

_____________________________________________________________________________

_____________________________________________________________________________

Printed Name of Physician ________________________________

Physician’s Phone Number ________________________________

Parent/Legal Guardian Signature __________________________

Physician’s Signature _________________________________

Physician’s Address _______________________________

Date ______________________________
Scholarship Application Form

A limited number of scholarships are available for the camp and enrichment programs at Easterseals Crossroads. Please complete this form to apply for a scholarship, and return it with your registration form. Please note that we can only scholarship one session of camp or enrichment programs and that the family is still responsible for the $100 deposit even if awarded the scholarship.

It is necessary to include a copy of your most recent tax return and the following if applicable:
- A copy of your last two month’s pay stubs
- If unemployed, a copy of your last two month’s unemployment check stubs
- Copy of paperwork documenting retirement, disability or social security benefits
- Copy of document citing child support or alimony awarded by a judge

This information will only be used to determine scholarship eligibility.

### CONSUMER INFORMATION

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th>Parent’s Name:</th>
</tr>
</thead>
</table>

### HOUSEHOLD INFORMATION

Number of family members in household:

- ___ Mother
- ___ Father
- ___ Children
- ___ Other Adults

**Gross** Annual Income (including parent’s earned income, child support, disability income, and worker’s compensation):

$ __________________

### SIGNATURE

Signature of individual providing information:

*Patient/Guardian signature*  
*Date*

For Office Use Only:

- ___ Scholarship approved and family notified
- ___ Scholarship denied and family notified
Before and After Care

Participant Name: ____________________________________________ Date: ______________________

Easterseals Crossroads is pleased to offer before and after care to children who participate in CampAbility. Families interested in receiving care, must complete the form below and attach the appropriate payment. The cost for before and after care is in addition to the regular camp fee. Please note the fee structure below. We encourage families to pre-arrange before and after care, as we cannot guarantee the availability of staff for care on an as-needed basis.

**Pre-arranged (on or before June 5, 2017):** $7 per hour, per child  
**As-needed basis (after June 5, 2017):** $10 per hour, per child

**Directions:** Please check (x) the boxes that express the dates/times you are interested in receiving before and after care for the above listed participant.

<table>
<thead>
<tr>
<th></th>
<th>Session 1: June 12 - June 22</th>
<th></th>
<th>Session 2: June 26 – July 7</th>
<th></th>
<th>Session 3: July 10 – July 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>8a – 9a @ $7</td>
<td></td>
<td>8a – 9a @ $7</td>
<td></td>
<td>8a – 9a @ $7</td>
</tr>
<tr>
<td></td>
<td>3p-4p @ $7</td>
<td></td>
<td>3p-4p @ $7</td>
<td></td>
<td>3p-4p @ $7</td>
</tr>
<tr>
<td></td>
<td>4p-5p @ $7</td>
<td></td>
<td>4p-5p @ $7</td>
<td></td>
<td>4p-5p @ $7</td>
</tr>
<tr>
<td></td>
<td>Payment</td>
<td></td>
<td>Payment</td>
<td></td>
<td>Payment</td>
</tr>
<tr>
<td></td>
<td>Total/Day</td>
<td></td>
<td>Total/Day</td>
<td></td>
<td>Total/Day</td>
</tr>
<tr>
<td>Monday, June 12</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Monday, June 26</td>
<td>$7</td>
</tr>
<tr>
<td>Tuesday, June 13</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Tuesday, June 27</td>
<td>$7</td>
</tr>
<tr>
<td>Wednesday, June 14</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Wednesday, June 28</td>
<td>$7</td>
</tr>
<tr>
<td>Thursday, June 15</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Thursday, June 29</td>
<td>$7</td>
</tr>
<tr>
<td>Monday, June 19</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Friday, June 30</td>
<td>$7</td>
</tr>
<tr>
<td>Tuesday, June 20</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Wednesday, July 5</td>
<td>$7</td>
</tr>
<tr>
<td>Wednesday, June 21</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Thursday, July 6</td>
<td>$7</td>
</tr>
<tr>
<td>Thursday, June 22</td>
<td>$7</td>
<td>3p-4p</td>
<td>$7</td>
<td>Friday, July 7</td>
<td>$7</td>
</tr>
<tr>
<td></td>
<td>TOTAL DUE: $</td>
<td></td>
<td>TOTAL DUE: $</td>
<td></td>
<td>TOTAL DUE: $</td>
</tr>
<tr>
<td>Session 1: June 12 - June 22</td>
<td>$</td>
<td></td>
<td>Session 2: June 26 – July 7</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Session 3: July 10 – July 20</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GRAND TOTAL DUE: $</td>
<td></td>
<td>(add totals from session 1, 2 and 3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I agree to pay the fees listed above. I understand that if plans change and I no longer need before or after care for my child on a date that I have indicated, I will be reimbursed those fees at the conclusion of camp.

Parent/Caregiver Signature: _____________________________ Date: ___________________________
Special Preparation and Food Allergy Plan
Supplemental Form

Participant Name: ___________________________ Date: ______________

<table>
<thead>
<tr>
<th>A. Special Food Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate texture of food needed:</td>
</tr>
<tr>
<td>☐ Regular ☐ Chopped ☐ Mechanical Soft ☐ Pureed</td>
</tr>
<tr>
<td>Indicate thickness of liquids needed (thickening agent must be provided by family):</td>
</tr>
<tr>
<td>☐ Regular ☐ Nectar ☐ Honey ☐ Pudding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Food Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>What food(s) is the participant allergic to?</td>
</tr>
<tr>
<td>☐ Milk/Dairy ☐ Eggs</td>
</tr>
<tr>
<td>☐ Peanuts ☐ Soy</td>
</tr>
<tr>
<td>☐ Gluten ☐ Wheat</td>
</tr>
<tr>
<td>☐ Dyes or coloring ☐ Other: ______________</td>
</tr>
<tr>
<td>Please specify: ______________</td>
</tr>
<tr>
<td>What type of contact induces an allergic reaction?</td>
</tr>
<tr>
<td>☐ Ingesting the allergen ☐ Eating near others with the allergen</td>
</tr>
<tr>
<td>☐ Ingesting food with the allergen ☐ Any exposure</td>
</tr>
<tr>
<td>☐ Other: ___________________________________</td>
</tr>
<tr>
<td>What signs will we see if the participant is having experiencing an allergic reaction?</td>
</tr>
<tr>
<td>☐ Skin rash/hives ☐ Difficulty breathing</td>
</tr>
<tr>
<td>☐ Upset stomach/bowels ☐ Anaphylaxis</td>
</tr>
<tr>
<td>☐ Swelling of lips ☐ Swelling in tongue</td>
</tr>
<tr>
<td>☐ Dizziness ☐ Drop in blood pressure</td>
</tr>
<tr>
<td>☐ Closed throat ☐ Other: _________________________</td>
</tr>
<tr>
<td>If experiencing an allergic reaction, will we see signs/symptom immediately or is there a delayed response? ________________________________</td>
</tr>
</tbody>
</table>
Please number the procedures below in order of desired emergency care:

_____ Call parent/guardian immediately participant is showing signs/symptoms of an allergic reaction.

_____ Call 911 if signs/symptoms of an allergic reaction appear.
  • Under what circumstances should staff contact 911? ____________________________

_____ Administer emergency medication (Epi-pen, inhaler, Benadryl).
  • Under what circumstances should staff administer emergency medication? ______________
  • Can the participant self-administer the emergency medication? □ yes □ no

Directions: Please complete the table below with a list of safe snacks and unsafe snacks for the participant. We cannot guarantee that safe snacks will be provided during respite events, so if your loved one has an allergy please be prepared to send them with a snack to the event so that they can enjoy in snack time with their peers.

<table>
<thead>
<tr>
<th>Safe Snacks</th>
<th>Unsafe Snacks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. General Information

Can the participant identify foods that are safe to eat? □ yes □ no
Can the participant inform an adult if they are having an allergic reaction? □ yes □ no

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

_________________________                ___________________
Parent Signature          Date

For staff use only:
This form was received and reviewed by:
_________________________                ___________________
Name / Title               Date
Seizure Action Plan
Supplemental Form

Participant Name: ___________________________ Date: ____________

Basic Information: Please provide background information on the nature of the seizures (i.e. type, triggers, length, etc.)

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Are there triggers/warning signs? __________________________________
   ___________________________________________________________________
2. How will the participant respond/behave once the seizure is over? __________
   ___________________________________________________________________

History & Management of Seizures:

1. When was the participant’s last seizure? ________________________________
2. Has the participant been hospitalized for continuous seizures? □ yes □ no
3. Does the participant have a Vagus Nerve Stimulator (VNS?) □ yes □ no
   B. Describe use of the magnet: _______________________________________
      __________________________________________________________________
4. Does the participant take medication(s) for their seizures? □ yes □ no
   A. Will this medication need to be administered at the Respite event? □ yes □ no

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route of administration (i.e: oral, rectal, etc.)</th>
<th>The medication is for emergencies only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
</tbody>
</table>

* If medication (including emergency meds) is needed during the Respite event, parents/caregivers must complete a medication administration form which will be provided at sign-in to each event. Medication must be in original container.
Seizure Emergency Protocol: please list out directions for staff to follow in the instance that the participant has a seizure during a Respite event.

Basic Seizure First Aid:
- Stay calm and track the time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with the child until they are fully conscious
- Protect the head
- If tonic clonic, place child on side and keep airway open for breathing

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

______________________________  ______________________________
Parent Signature     Date

For staff use only:
This form was received and reviewed by:

______________________________  ______________________________
Name / Title     Date
# G-tube Feeding Plan & Emergency Action Plan Supplemental Form

**Participant Name:** _________________________________ **Date:** __________

## TYPE OF TUBE

1. **What type of tube does the participant have:**
   - [ ] Nasogastric
   - [ ] Orogastric
   - [ ] Gastrostomy
   - [ ] Percutaneous Endoscopic Gastrostomy
   - [ ] Jejunostomy

2. **Does the feeding tube have more than one port?**
   - [ ] Yes
   - [ ] No

   *If yes, each port must be clearly labeled so that we are aware of which one is for medication, which one is for feeding, and which one is to inflate the balloon.*

## MEDICATION ADMINISTRATION

3. **Will the participant require medication administration through their tube during respite events?**
   - [ ] Yes
   - [ ] No

   **(If yes, please continue below. If no, skip to question 4).**

   **A). If a non-liquid medication, how should this medication be administered?**
   - [ ] Crushed
   - [ ] Dissolved in water
   - [ ] Other: ____________________________

   **B). If multiple medications, can the medication be administered all together?**
   - [ ] Yes
   - [ ] No

   **C). Does the participant require a water flush after medication administration?**
   - [ ] Yes
   - [ ] No; If yes, please explain: ____________________________

## FEEDING INSTRUCTIONS

4. **The participant has a doctor’s order and is on a specific feeding schedule which will require a feeding during Respite events**
   - [ ] Yes
   - [ ] No

   **(If yes, please continue below. If no, please skip to question 5).**

   **A). What type of formula feeding does the participant consume?**
   ____________________________

   **B). How much of the formula should be given to the participant?**
   ____________________________

   **C). Does the participant require a water flush after a feeding?**
   - [ ] Yes
   - [ ] No; If yes, please explain: ____________________________
D.) Should we expect to have difficulties with the tube clogging? □ Yes  □ No
If yes, please explain how to unclog the tube: _______________________
______________________________________________________________

**EMERGENCY CARE INSTRUCTIONS**

5. If we see drainage around the g-tube area, how should we care for and clean the affected area?
(check all that apply and explain below)

- □ Soap & water
- □ Antiseptic solution
- □ Ointment
- □ Cover with g-tube gauze
- □ Other: ____________________

Please explain: ______________________________________________________________________
__________________________________________________________________________________

5. Should the g-tube happen to come out during a Respite event, how long can the tube be out before the stoma closes up? ____________________

A). Please list the procedures we should follow if the g-tube comes out during a Respite event.

<table>
<thead>
<tr>
<th>If the participants g-tube falls out, please follow the procedures below:</th>
<th>Call 911 immediately if...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

**By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. I agree to train the Respite staff on the care and feeding of the participant listed above. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.**

____________________________________________________________________________________
Parent Signature          Date

**For staff use only:**
This form was received and reviewed by:

____________________________________________________________________________________
Name / Title          Date
Frequently Asked Questions

What should the participant bring to camp?
- Extra change of clothes (or two!)
- A pair of long pants
- Diapers, pull-ups, or extra underwear; wipes
- Sunscreen, swim diaper, swimsuit, towel, sandals (for water play)
- A sack lunch – we do have access to a refrigerator
- A cup – if a special one is needed for drinking
- A snack (if your child has specific dietary restrictions)
- Medication - be sure to notify staff if medications are needed
- Sensory toys/chewable toys (if needed)
- Communication device (if applicable)

What should the participant wear to camp?
- Comfy clothes – shorts, light t-shirts, etc.
- Camp shirt – on field trip days only
- Gym shoes / closed toed shoes
- It gets chilly at times in our classrooms! An extra sweater or sweatshirt is also recommended!

Will there be an open-house where my child can meet the staff and see their classroom?
Yes! We have scheduled an open house on Thursday, June 8, from 5-6 at the camp site where you have registered. Bring your child and show them their classroom, introduce them to staff and get the camp calendar so you will know what fun-filled activities we have scheduled! 🙂

‘Typical’ camp schedule
9:00-9:30: welcome / circle time
9:30-10:30: exercise time / gross motor activities
10:30-11:30: water play
  - we have small swimming pools (less than 2 ft deep), water slides, sprinklers and water toys
11:30-1:00: lunch and recess
1:00-2:30: stations
  - arts and crafts
  - snack time
  - circle time
2:30-3:00: home rooms for play / prepare to go home

Sick policy
We want to ensure that all children that come to camp are healthy and free of illness so that others do not get sick. Children attending camp must be free from fever, vomiting, and/or diarrhea for 24 hours. In addition, children must be not present with a contagious illness. Should your child be ill, please contact Angie Hilligoss at 317-662.4398. Additionally, if your child becomes ill while with us at camp, we will contact you to arrange pick-up.