Summer Respite Camp

What happens during Summer Respite Camp?

- Fun, Fun, and more Fun
- Outdoor activities and indoor activities
- Social activities and field trips
- Academic skills enhancement

Who is eligible?

Youth between the ages of 9 and 17 with a diagnosed disability or developmental delay. We will request to meet your son or daughter prior to acceptance into the program to ensure that it is a good fit for your son or daughter and to ensure that we can meet their needs. Completion of an application does not guarantee participation in the camp. You will be notified weeks prior to camp if your child has a camp slot. Please complete and return the application on or before **May 13, 2022**.

To apply:

Complete the camper application including the following:

- The Application Form (may be completed on-line and emailed or mailed) www.rauchinc.org
- A Medical Form (a physician signature is required)
- A Parental Waiver and Consent Form
- An Acknowledgement of Notice of Privacy Practices

Return the completed application to:
Rauch, Inc.
Developmental Summer Respite Youth Camp
Attn: Amelia Williams
2525 Charlestown Road
New Albany, Indiana 47150
Fax (812) 941-5239
Email: awilliams@rauchinc.org
If you have any questions, please call us at 812-945-4063 or 812-542-3651

Camp Dates:	**June 13**	**June 17**	**Session 1**
	June 20	**June 24**	**Session 2**
	June 27	**July1**	**Session 3**
	July 5	**July 8**	**Session 4 (4th holiday)**

Payment: Private Pay or Medicaid Waiver
Medicaid Waiver: Based upon the participants needs
Scholarships: Limited scholarships based upon proof of financial need

Developmental Youth Summer Respite Camp Application

Please print:

Name_____

Birth date ____/____/_____ Age _____ Grade entering_____ M/F _____

Primary Diagnosis/Condition(s):_____

Primary Treating Physician:_____

Physician Office Number (_____) _____

Case Manager Name: _____ **Phone Number:** _____

Social Security Number: _____

Contact Information:

Parent or Guardian Name_____

Street Address _____County_____

City _____ State _____ Zip Code _____

Home Number (____) _____ Work (_____)_____ Cell (_____)_____

Email _____Fax (_____) _____

Emergency information:

In case of emergency, <u>if the parent cannot be reached</u>, please contact:

Name: _____ Relationship_____

Home Number (____) _____ Work (_____)_____ Cell (____)_____

How did you hear about Camp? ☐Friends/family member ☐ Media
☐ Hospital/Care Center (specify) _____
☐ Organization (specify) _____
☐ Website (specify) _____

Form completed by: _____

Relationship to Camper: _____

Developmental Youth Summer Respite Camp Medical Form

(Primary Treating Physician must sign)

This form is good for up to one year only

Name:_____ Nickname:_____

Age:____ Birth date:_____/_____/_____ Ethnicity:_____ ☐ESL:_____

Primary diagnosis? _____

Secondary diagnosis? (If applicable)_____

Any other current problem(s)?_____

Functions at what grade level:_____ Height:_____ Weight (lbs.):_____ Blood Pressure:_____

Please indicate if Within Normal Limits? If no, please explain.

Vision	☐ YES	☐ NO	Comments:_____
Hearing	☐ YES	☐ NO	Comments:_____
Teeth	☐ YES	☐ NO	Comments:_____
Skin	☐ YES	☐ NO	Comments:_____
Speech	☐ YES	☐ NO	Comments:_____
Reading Ability	☐ YES	☐ NO	Comments:_____

Please indicate and explain if the child has/uses any of the following:

☐ Home Care Services
Contact Person:_____
Phone Number:_____

☐ Dietary Restrictions:_____
_____

☐ Food Allergies:_____
_____

☐ Medication Allergies:_____
_____

☐ No Allergies

☐ Activity Restrictions: _____
_____

☐ Enlarged spleen or liver**:**_____
_____

☐ Pull Ups/Diapers
☐ Adaptive Devices
☐ Wheelchair
☐ Walker/Crutches
☐ Splint/Braces
☐ Artificial Limb
☐ G-Tube
☐ Other:_____

List any hospitalizations/surgeries in the past year?

1._____ Date:_____
2._____ Date: _____

Please list all medications and supplies.
Please list all medications including OTC meds the child takes.

Medication Name	Dosage	Times of Administration	Route medication to be given	Purpose of Medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please attach side effects of each medication to this form

Is he/she able to self medicate? ☐ YES ☐ NO
Does child desire to self medicate? ☐ YES ☐ NO

Are immunizations up-to-date? ☐ YES ☐ NO ****Immunizations must be up-to-date to attend camp. Attach current immunization certificate *** <u>Rauch staff do not administer medication</u>*****

Behavioral

When your son/daughter becomes angry, frustrated, or upset, what is their typical behavior and our best response to it?_____
_____

How does your child interact in a group of children of the same age?_____
_____
_____

How often does your child require close (one on one) supervision? Comments?
☐ All of the time, _____
☐ Some of the time, _____
☐ None of the time, _____

Other comments?_____
_____
_____

Please complete information as applicable to child's illness/condition.

Asthma ☐ **Not Applicable**

Classification:
☐ Mild Intermittent (1)
☐ Mild Persistent (2)
☐ Moderate Persistent (3)
☐ Severe (4)

Due to asthma, within the last year, how many times has your child:
Missed school? _____
Visited the ER or urgent care clinic? _____
Admitted to hospital? _____

Please indicate if camper has/had any of the following:
☐ Systemic Corticoid Steroid Treatment
☐ Known Triggers,
Describe:_____
☐ Anaphylaxis Reaction
Describe:_____
☐ Exercise induced asthma?
Comments:_____
☐ Does this child have an asthma action plan? **If yes, please attach.**

Type of seizure:
☐ Partial
☐ Generalized ☐ Convulsive
☐ Nonconvulsive

☐ Daily how many?_____
☐ Weekly how many?_____
☐ Monthly how many?_____
☐ Yearly how many?_____
☐ None in past year

Describe the behavior after (postical) a seizure?_____
_____
_____
_____

In general, what tends to bring on a seizure? i.e. being overly excited, overly tired, etc._____
_____
_____

Seizures typically occur how often?

Heart ☐ **Not Applicable**

☐ Pacemaker — If YES, what type?_____
☐ Heart Transplant — If YES, give date:_____
☐ Pulmonary Hypertension — If YES, give treatment:_____
☐ Decreased Ventricular Function — If YES, indicate: ( ) RV ( ) LV ( ) SV
☐ Require Oxygen — If YES, amount?_____

Irritable Bowel/ Crohn's Disease ☐ **Not Applicable**

Indicate if the child has any of the following symptoms:
☐ Diarrhea Comments:_____
☐ Constipation Comments:_____
☐ Abdominal Pain Comments:_____
☐ Colostomy Comments:_____
☐ Nausea/Vomiting Comments:_____
☐ Weight Loss Comments:_____

Please list any special dietary requirements
1.
2.

Physical Disability/CP ☐ **Not Applicable**
(including: Traumatic Brain Injury, Spinal Cord Injury, Encephalopathy)

Indicate Rancho Scale rating (if applicable):
_____

What level is spinal cord injury (if applicable)?_____

☐ Bowel Incontinence
Describe program:_____
_____

☐ Bladder Incontinence
Describe program:_____

Spina Bifida ☐ **Not Applicable**

Indicate type:
☐ Occulta
☐ Meninocele
☐ Myelomeningocele

Neurosurgeon:_____
Phone Number:_____

☐ Shunt

☐ Bowel Incontinence
Describe program:
_____
_____
_____

Describe program:
_____
_____
_____

Catherization Schedule:
_____am/pm
_____am/pm
_____am/pm
_____am/pm

Child has the following: ☐ Bladder Incontinence
Please provide any information that would be beneficial for us to know to provide the best possible experience.
_____
_____

Physician's Statement: I have reviewed the records and examined _____ and find him/her to be physically able to attend camp.

Physician/Nurse Practitioner's Signature _____Date ___/___/___

Physician/Nurse Practitioner's Name (PRINT) _____

Address_____ City _____

State_____ Zip Code_____Office Phone (___) _____ Fax (___)_____

Emergency Contact Number (____)_____

Parental Waiver and Consent Form

Authorization and Acknowledgment: By signing this waiver and consent, I, the legal parent/guardian grant permission for my child to participate in any and all activities for Developmental Kid's & Youth Respite Camp unless specified otherwise on the **Application Medical Form or Family Member Medical Form**. I recognize and acknowledge the inherent risks that these activities may present for my child.

Medical Consent: The Rauch staff will make every effort to contact me in the case of an emergency. I give my permission for Rauch and its staff to administer medication and to provide and arrange for any necessary medical treatment to my child while at the Center, including onsite and offsite emergency care. I accept responsibility for the costs of all such medical treatment.

Participation Release and Waiver: Because I acknowledge the risks of allowing my child to participate, I agree to release and hold harmless the Center and its founder, trustees, directors, officers, employees, agents, volunteers and staff ("Staff") from any and all injury claims of any other nature which may result from my child's participation at and travel to or from the Center to community activities. I agree to indemnify and hold Rauch, Inc. its Staff and other children at Rauch harmless from any and all liability caused by my child, whether or not intentional.

Photography Release: In consideration of my child's participation at Rauch, Inc. and without any further consideration from Rauch, Inc. I hereby grant permission to Rauch and its staff to utilize my appearance, performance or voice in any and all manner and media throughout the world for the purpose of promoting, reporting or publicizing the services. Rauch may use my child's name, likeness, voice and biographical material in connection with publication, promotion, exhibition and distribution of such materials. I understand that no royalty, fee or any other compensation of any kind shall become payable to me by reason of such release and use of any photograph.

Please contact the office if you have any questions before signing. The number is (812) 945-4063.
I have read this form carefully and have had all questions answered before signing this legal document and giving the consents and waivers contained in it. I acknowledge that this is a legal document and I will be bound by my agreement to its terms. I represent to the Center that I have the legal authority to provide consent on behalf of my child.

Child's Name:_____

Parent/Guardian must sign. Signature represents legal authority for child listed above.

Parent/Guardian, Print Name: _____

Parent/Guardian, Signature: _____ Date: _____