Rauch's Seasonal Camp Application

Child's Information:

Child's Name: ____

Birthdate: ________/________/________ Age: ________ M/F: ________

Race: _______________ Ethnicity: _____________ Height: __________ Weight: ____________

School: ____ Grade: __________

Social Security Number: ____

Primary Physician: ________________________________ Phone: ___________________________

Specialist (If applicable): __________________________________Phone: ____________________

Therapist (If applicable): __________________________________Phone: ____________________

Psychiatrist (If applicable): __________________________________Phone: __________________

Case Manager (If applicable): __________________________________ Phone: _________________

Email: ____

Behavior Specialist (If applicable): ________________________________Phone: ________________

Email: ____

Contact Information:

Parent or Guardian Name: ____

Street Address: ____

City: __________________________________ State: _______ Zip Code: _______________

Cell: (____) ______________ Work: (_____)_______________ Home: (_____)________________

Email: ____

Emergency Information:

In case of emergency, if the parent cannot be reached, please contact:

Name: _________________________________ Relationship: __________________________

Cell: (____) ______________ Work: (_____) ________________ Home: (_____) ______________

How did you hear about our camp?

____

Medical Information

Name: ______________________________ Nickname: ______________

Primary diagnosis? ______________________________

Secondary diagnosis? (If applicable) ______________________________

Other Diagnosis: (If applicable): ______________________________

Any other current issue(s)? ______________________________

Physical Restrictions: ______________________________

Please complete information as applicable to the child's condition:

Please indicate if within standard limits? If no, please explain

Vision ☐ YES ☐ NO Comments: ______________________________

Hearing ☐ 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:

- ☐ G-Tube
- ☐ Enlarged spleen or liver
- ☐ Pull Ups/Diapers
- ☐ Adaptive Devices
- ☐ Wheelchair
- ☐ Walker/Crutches
- ☐ Splint/Braces
- ☐ Artificial Limb
- ☐ Other: ______________

Please indicate if the child has any of the following:

☐ Dietary restrictions: ______________________________

____

☐ Food Allergies: ______________________________

____

☐ Medication Allergies: ______________________________

____

☐ Any other noted Allergies: ______________________________

____

☐ Activity restrictions: ______________________________

____

Asthma ☐ **Not Applicable**

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

☐ Does this child have an asthma action plan? **If yes, please attach.**

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?
____

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:____

Seizure ☐ **Not Applicable**

Classification:
☐ Partial
☐ Generalized
☐ Convulsive
☐ Non-convulsive

Seizures typically occur how often?
☐ Daily how many?_________
☐ Weekly how many?_________
☐ Monthly how many?_________
☐ Yearly how many?_________
☐ None in past year

Describe the behavior during a seizure?
____
____

Describe the behavior after a seizure?
____
____

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

What do we need to do? When do we need to call you?
____
____
____

Behavioral

When your son/daughter becomes angry, frustrated, or upset what is their typical behavior?

What is the best way to handle the behavior?

How does your child interact in a group of children of the same or similar 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

Any other comments?

Healthy and Safe Environment Plan

Seizure Management: Yes__ No__ N/A __ (Describe the treatment and interventions to assist the individual)

Toileting Assistance: Yes__ No__ N/A __ (Describe the treatment and interventions to assist the individual)

Swallowing/Eating Considerations: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Communication Needs: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Diet and Nutrition: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Behavior Management: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Significant Health Concerns: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Mobility/Safety Issues: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Emotional and Physical Crisis: Yes__ No__ N/A__ (Describe the treatment and interventions to assist the individual)

Conduct and Participate in Emergency Drills and Evacuations: Yes__ No__ N/A__
(Describe and assistance the individual needs in the event of an emergency)

Medication/Side Effects: Yes__ No__ N/A__ (Medications and Side Effects listed on next page)
(Describe the treatment and interventions to assist the individual)

Cultural Assessment: Yes__ No (Refused Discussion)__ N/A__ (Describe the cultural preference of the individual)
(Cultural – The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethical, religious, social, or other groups.)

Medication

Medication:____
Side Effects:____
Prescribing Doctor: _________________________ **Frequency of Dosage:** _______________
Medication Taken: Independently__ Supervised__ Unable (Staff Administer)__Other:_____________
Dosage Method: Sublingual__ Oral__ Topical__ Injection__ Dermal Patch__ IV Drop__ Eye Drops__
Nasal Spray__ Other___

Medication: ____
Side Effects: ____
Prescribing Doctor: ____________________________ **Frequency of Dosage:** _____________
Medication Taken: Independently__ Supervised__ Unable (Staff Administer)__ Other:_______________
Dosage Method: Sublingual__ Oral__ Topical__ Injection__ Dermal Patch__ IV Drop__ Eye Drops__
Nasal Spray__ Other_______

Medication: ____
Side Effects: ____
Prescribing Doctor: ____________________________ **Frequency of Dosage:** _____________
Medication Taken: Independently__ Supervised__ Unable (Staff Administer)__ Other:______________
Dosage Method: Sublingual__ Oral__ Topical__ Injection__ Dermal Patch__ IV Drop__ Eye Drops__
Nasal Spray__ Other_______

Medication: ____
Side Effects: ____
Prescribing Doctor: ____________________________ **Frequency of Dosage:** _____________
Medication Taken: Independently__ Supervised__ Unable (Staff Administer)__ Other:_______________
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Nasal Spray__ Other_______

Medication:____
Side Effects:____
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Nasal Spray__ Other_______

****Rauch staff cannot administer or store medication.**
Please make arrangements for medication administration**

<u>Medical Treatment Release</u>
In the event that the above person needs immediate medical attention, I give my permission for Rauch, Inc. staff to take the above named person to receive treatment by a professional medical staff.

Signature: ____ Date: ______________________

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 Rauch Seasonal Children's Camp unless specified otherwise on the **DKYC Respite Camper Medical Form or Family Member Medical Form**. I recognize and acknowledge the inherent risks that these activities may present for my child.

Medical Consent Yes________ No_________ Initial__________

The Rauch staff will make every effort to contact me in 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 Yes________ No_________ Initial__________

Because I acknowledge the risks of allowing my child to participate, I agree to release and hold harmless Rauch, Inc. and its founder, trustees, directors, officers, employees, agents, volunteers and 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 camp to community activities. I agree to indemnify and hold Rauch, its staff and other participants at Rauch, Inc. harmless from any and all liability caused by my child, whether or not intentional.

Photography Release Yes________ No_________ Initial__________

In consideration of my child's participation at Rauch, and without any further consideration from Rauch, I hereby grant permission to Rauch and its staff to utilize my child's **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, photo, 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) 542-3651. 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 Rauch that I have the legal authority to provide consent on behalf of my child.

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

Child's Name: ____

Parent/Guardian Name: ____

Parent/Guardian Signature: ___________________________________ Date: ___________________