

# EASTER SEALS NEBRASKA – PARTICIPANT APPLICATION

## CAMPER INFORMATION

Last Name		First Name		MI	Nickname	
Address		City		ST	ZIP	
County		Phone		Birthday		
Email Address						
Heritage						Gender
<input type="checkbox"/> African American	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Male		
<input type="checkbox"/> Asian American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Other _____	<input type="checkbox"/> Female		
Health Insurance Carrier						
Address		City		ST	ZIP	
Name of Primary Insured			Relationship to Participant			

## PARENT / CARE PROVIDER INFORMATION

Parent's / Care Provider's Name			Phone		
Address (If different from participant)		City	ST	ZIP	
Parent's / Caregiver's Occupation			Parent's / Caregiver's Employer		
Preferred Contact		Relationship to Participant		Phone	
Emergency Contact		Relationship to Participant		Phone	

## PARTICIPANT'S DIAGNOSIS (check all that may apply)

Height _____	Weight _____	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Dyslexia	<input type="checkbox"/> Obesity
<input type="checkbox"/> Autism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Blind	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Spina Bifida – walks
<input type="checkbox"/> Cerebral Palsy - walks	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Spina Bifida – wheelchair
<input type="checkbox"/> Cerebral Palsy – wheelchair	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Spinal Cord Injury – paraplegic
<input type="checkbox"/> Deaf	<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Spinal Cord Injury – quadriplegic
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Visually Impaired
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other _____

## ABILITY INFORMATION

<b>Vision</b>		
<input type="checkbox"/> Sighted	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Legally Blind
<input type="checkbox"/> Partially Sighted	<input type="checkbox"/> Color Blind	<input type="checkbox"/> Other _____

<b>Hearing</b>		
<input type="checkbox"/> Normal	<input type="checkbox"/> Partial Hearing	<input type="checkbox"/> Legally Deaf
<input type="checkbox"/> Normal with Aid	<input type="checkbox"/> Partial Hearing with Aid	<input type="checkbox"/> Other _____

### Communication

Is the camper able to understand and communicate his/her needs to others? Ex. Food, thirsty, bathroom, medical assistance?  Yes  No

<input type="checkbox"/> Verbal	<input type="checkbox"/> Communication Board	<input type="checkbox"/> PECS	<input type="checkbox"/> Gestures
<input type="checkbox"/> Non-Verbal	<input type="checkbox"/> Electronic Device	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Other _____

### Mobility

<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Wheelchair – Power	<input type="checkbox"/> Cane
<input type="checkbox"/> Wheelchair – Manual	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker

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## ABILITY INFORMATION (continued)

### Seizure Activity

None       Petit Mal       Grand Mal      Frequency: \_\_\_\_\_      Duration: \_\_\_\_\_

Please describe the camper Before, During and After the seizure:

\_\_\_\_\_  
\_\_\_\_\_

### Transfers

Standby       Two Person       Hoyer Lift       Other \_\_\_\_\_  
 Independent       Stand and Pivot       One Person Total Lift       None

### Adaptive Devices

None       AFO's       Night Braces       Prosthesis       Shunt  
 Helmet       Glasses       Hearing Aids       Dentures       Other \_\_\_\_\_

### Other Medical Items to be Aware of

Shunt       Rods       Other \_\_\_\_\_

## GENERAL BEHAVIOR (check all that may apply)

Generally Easy Going/Happy       Unsure of New Situations       Temper Tantrums  
 Shy/Withdrawn       Verbally Aggressive/Demanding       Bites  
 Helpful       Wanders/Needs Constant Direction       Yells/Screams  
 Physically Aggressive       Self-Injurious       Other

If other, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific behavior modification techniques to assist counselors:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PERSONAL CARE INFORMATION

### Eating

No Assist       Partial Assist       Total Assist

If Partial, Please Explain:

List Adaptive Equipment Used for Eating: \_\_\_\_\_

### Diet

Normal       Chopped Food       Blended/Puree       Low Calorie  
 Low Salt       Low Cholesterol       Diabetic       Low Fat  
 G-Tube Only       G-Tube and Oral Foods

Any other special diet: \_\_\_\_\_

Does the camper have any difficulty swallowing?  Yes  No

List problem foods or any food allergies. \_\_\_\_\_

### Toileting

Bladder Control       Normal/No Assist       Occasional Incontinence/Bed wetter  
 Partial Assist       Total Assist       Needs Reminder

Bowel Control       No Assist       Partial Assist       Total Assist

Aids Used       None       Needs Reminder       Urinal       Bedpan  
 Briefs       Toilet Chair       Ostomy       Night Briefs

Other, please specify: \_\_\_\_\_

Catheterization       Self/Independent       Intermittent       Dependent/Nurse  
 Indwelling Catheter       Condom Catheter       Needs Reminder

Catheter schedule \_\_\_\_\_

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## PERSONAL CARE INFORMATION (continued)

Menstrual Care     Non-applicable     No Assist  
                           Needs Reminder     Partial Assist     Total Assist

### Washing/Showering

No Assist     Partial Assist     Total Assist

### Dressing

No Assist     Partial Assist     Total Assist

### Sleeping

Sleepwalks  Yes  No    Needs to be awakened or turned during the night  Yes  No

Can camper sleep on an upper bunk?  Yes  No

## MEDICATION INFORMATION

Does the camper have any allergies?     Yes     No

If Yes, please list: \_\_\_\_\_

Does the camper take any medication:     Yes     No

If Yes, Please fill out the enclosed Medication sheet.

As per standing orders authorized by Dr. Thomas A. McKnight, Easter Seals Nebraska medical staff is permitted to give the camper over-the-counter medication and treatment for minor injuries and illness. These medications include but are not limited to Pepto-Bismol, Tylenol, Advil, Antacids, Itch Creams, etc.

Parent/Guardian Signature    **X** \_\_\_\_\_

## OTHER INFORMATION ABOUT THE PARTICIPANT

Camper's T-Shirt Size:     Youth Small     Youth Medium     Youth Large  
                                   Adult Small     Adult Medium     Adult Large  
                                   Adult X-Large     Adult XX-Large     Adult XXX-Large

Has the camper stayed away from home before?  Yes  No

What are the camper's main interests? (hobbies, activities, etc.)

\_\_\_\_\_

Please tell us what the parent's/caregiver's and camper's goals are in this camping adventure. While we may not be able to make every accommodation, we want camp to be a rewarding experience for each camper.

Parent's/Caregiver's Goals for Camper:

\_\_\_\_\_

Camper's Goals:

\_\_\_\_\_

## PHOTO RELEASE FORM

I give Easter Seals Nebraska (ESN) permission to use any photographs/video of the participant taken at camp in future promotion of Easter Seals Nebraska Camp, Mid-America Council, Boy Scouts of America and other partner organizations.

Name of Participant \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# EASTER SEALS NEBRASKA – PARTICIPANT APPLICATION

## CAMPER'S RIGHTS

In accordance with State of Nebraska Department of Health and Human Services and the policy of Easter Seals Nebraska; we want you and your camper to be aware of our assurance to you that we will adhere to the following rights:

1. To be treated with dignity and respect
2. Receive services without regard to race, color, religion, sex, disability, marital status, national origin or age
3. Receive a camp introduction and orientation
4. Make choices and participate in decision making
5. Receive appropriate services according to their needs
6. Receive services in the least restrictive environment
7. Have a camp setting that is sanitary and safe
8. Exercise the same civil rights as other citizens
9. Maintain Privacy
10. Keep personal possessions
11. Participate in the management of any money left for them
12. Communicate freely by mail, (and by telephone during free time and program breaks)
13. Be free from neglect and abuse
14. Have an appropriate and nutritious diet
15. Receive appropriate medical treatment
16. Receive due process in handling of grievances

Name of Participant \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL INFORMATION

Name of Party Responsible for Payment \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

### Private Funding

How will payment be made:  In full with application – Registration fee not required, savings of \$75  
 Deposit with Balance – Due one week before session  
 Deposit with Monthly Payments – Final payment due 8/31/05

Number of Monthly Payments \_\_\_\_\_

Amount of Monthly Payments \_\_\_\_\_

Method of Payment  Money Order  Check  Credit Card

Amount Enclosed \_\_\_\_\_ Check Number \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_

### Government Funding

Type of Waiver  Developmental Disabilities  Aged & Disabled  
 Nebraska Lifespan Respite  Other \_\_\_\_\_  
 League of Human Dignity

Have your requested authorization?  Yes  No Authorization Number \_\_\_\_\_

Service Coordinator \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

### Outside Funding

Is an outside organization sponsoring the camper?  Yes  No

Will Easter Seals Nebraska need to send them an invoice?  Yes  No

Organization's Name \_\_\_\_\_ Contact Person \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Amount of Scholarship \_\_\_\_\_

# EASTER SEALS NEBRASKA – PARTICIPANT APPLICATION

## FINANCIAL INFORMATION (continued)

### Easter Seals Nebraska Scholarship

Have you received assistance from us before?  Yes  No

Program  Camp  Respite When \_\_\_\_\_

Please contact our office at (402) 345-2200 or 1-800-650-9880 for further scholarship information. Easter Seals Nebraska is dedicated to giving everyone an enjoyable camp experience; however, at this time we are unable to extend full scholarships due to the increase in our camper's needs.

## CAMP SESSIONS AND COST

This year it will cost Easter Seals Nebraska approximately \$240.00 per day to provide camp. For a 5 day program this equals approximately \$1200.00. Please note the actual fee next to the session is your cost of camp. It is through the continuous generosity of our donors that we are able to offer camp fee below the actual cost.

### Camp Session First Choice

**The cost of each session is \$650.00**

### Camp Session Second Choice

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | June 10-15, 2007 Young Adults             |
| <input type="checkbox"/> | June 19-24 2007 Autism Camp for Youth     |
| <input type="checkbox"/> | June 26-July 1 2007 Autism Camp for Teens |
| <input type="checkbox"/> | July 8-13, 2007 Teens                     |
| <input type="checkbox"/> | July 15-20, 2007 Youth                    |
| <input type="checkbox"/> | July 22-27, 2007 Young Adults             |
| <input type="checkbox"/> | July 29-Aug 3, 2007 Teens                 |
| <input type="checkbox"/> | August 5-10, 2007 Youth                   |
| <input type="checkbox"/> | August 12-17, 2007 Adults                 |

- |                          |                           |
|--------------------------|---------------------------|
| <input type="checkbox"/> | Youth – Ages 6-12         |
| <input type="checkbox"/> | Teens – Ages 13-19        |
| <input type="checkbox"/> | Young Adults – Ages 20-35 |
| <input type="checkbox"/> | Adults – Ages 35 and up   |

### Optional Specialty Camps

- |                          |                |
|--------------------------|----------------|
| <input type="checkbox"/> | Horseback Camp |
| <input type="checkbox"/> | Boy Scout Camp |

**Optional Specialty Camps:** Please mark the appropriate box if you would be interested in a 2 day specialty camp, held during your regular camp week, **for an additional cost of \$20.00. Payment for this camp needs to be sent in along with the registration fee.** Please see the back of the white Guidelines for Registration form for more detailed information.

## THE FINE PRINT

### Registration

A \$75 registration fee is required per session attending. The registration fee is separate from the camp fee and is non refundable. Registrations will not be processed unless accompanied by the registration fee.

Nonrefundable registration fee of \$75.00 is enclosed  Yes  No

### Arrival

A confirmation letter with your arrival/check-in time will be mailed to you in May.

### Departure

On camp departure day, campers will eat a late breakfast and snacks will be provided, but lunch will **not** be served. Family and friends are invited to the closing program which begins at **11 am**. Departure from the camp is **NOON**.

### Dates to Remember

Application Deadline: April 6, 2007

Camp Registration Closes on May 31, 2007. Applications may not be accepted after this date.

### Miscellaneous

Have you attended an Easter Seals Nebraska (ESN) camp or Mini-Respite before?  Yes  No

If no, how did you hear about Easter Seals Nebraska \_\_\_\_\_

Information Completed By (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Phone \_\_\_\_\_

### **FOR OFFICE USE ONLE**

Received	Deposit	Cash	Check #	Credit Card	Amount	Waiver	Days	Amount
ACA Form	Confirm	Check List	Scout	Scholarship	Request	Given	Grantor	Paid