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. We may 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.

To apply:

Complete the Camper application:

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

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 5, 2017**.

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 5 June 16**	**Session 1**
	June 19 June 30	**Session 2**
	July 3 July 7	**Session 3**

Cost: $150.00 per week: Private Pay

Medicaid Waiver – based upon the participants needs

Limited scholarships based upon financial need

Summer Respite Camp Client Information Sheet

Name: ______________________________
Address: ______________________________
City: ____________ ST: ____ ZIP: ______ CTY: ________
Phone#: Home (____) _____-________ Cell (____) _____-________
Date: _______Start Date: ______ E-Mail Address: ______________

RID #:______________________ ______________________

Social Security#:______________________

DOB: ______________ Sex: M F Race: Caucasian__ Hispanic__ African American__ Other: ________

Education: Grade Completed___ High School Dip.__ Spec. ED__ Alternative__ GED__ Unknown__ Other: ____

Guardian: Yes__ No__ Name: ______________________Relationship: __________
Address: ______________ City: _______ST: _____Zip: __________
Phone: H (___)____-_____ C (___)____-_____ E-Mail: ______________

Emergency Contacts: Name: ______________________Relationship: __________
Address: ______________ City: _______ST: _____Zip: __________
Phone: H (___)____-_____ C (___)____-_____ E-Mail: ______________
Name: ______________________Relationship: __________
Address: ______________ City: _______ST: _____Zip: __________
Phone: H (___)____-_____ C (___)____-_____ E-Mail: ______________
Name: ______________________Relationship: __________
Address: ______________ City: _______ST: _____Zip: __________
Phone: H (___)____-_____ C (___)____-_____ E-Mail: ______________

Primary Diagnosis: ______________________________
Secondary Diagnosis: ______________________________
Other Diagnosis: ______________________________
Physical Restrictions: ______________________________
ALLERGIES: ______________________________

Primary Physician: Name: ______________________Phone: ______________
Address: ______________ City: ________ ST: ______ Zip: ________

Therapist: Name: ______________________Phone: ______________
Address: ______________ City: ________ ST: ______ Zip: ________

Psychiatrist: Name: ______________________Phone: ______________
Address: ______________ City: ________ ST: ______ Zip: ________

Specialist: Name: ______________________Phone: ______________
Address: ______________ City: ________ ST: ______ Zip: ________

Name: ______________________________

Case Manager: Name: ______________________________

Address: ______________________ City: _______ST: _____Zip: ___________

Phone: H (___)____-_____ C(___)____-_____ E-Mail: ______________________

Behavior Specialist: Name: ______________________________

Address: ______________________ City: _______ST: _____Zip: ___________

Phone: H (___)____-_____ C(___)____-_____ E-Mail: ______________________

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.)

____

____

Name: ______________________________

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**

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

Describe the behavior after (postical) a seizure?______________________
____
____
____

Seizures typically occur how often?

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

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

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: ________