Midnight Farm Day Camps
Community Living Opportunities, Inc.
2125 Delaware Street
Lawrence, KS 66046

CAMPER INFORMATION

Last Name:______________________ First Name:__________________ NickName:__________

Street Address:__________________________ City, State: _______________ Zip Code: _____ Gender: ☐ M ☐ F

PARENT/GUARDIAN INFORMATION (place check mark next to address to which acceptance information should be sent)

Custodial Parent/Guardian:__________________ Home Phone:_____________ Work Phone:____________

Street Address:__________________________ City, State: _______________ Zip Code: ___________

2nd Custodial Parent/Guardian:________________ Home Phone:_____________ Work Phone:____________

Street Address:__________________________ City, State: _______________ Zip Code: ___________

ALTERNATIVE EMERGENCY CONTACTS (other then parent/guardian listed above)

Name: ______________________ Relationship to Camper:____________________ Phone Number: ______________

2011 CAMP DATES

Please *indicate the camp activities for which the applicant is applying.*

Camp Dates	Parent Training	Therapeutic Horseback Riding
Kids Camp ○ March 14-18th ○ May 31st-June 3rd ○ July 25th-29th	Available at Camp Sessions ○ March 14-18th ○ May 31st-June 3rd ○ July 25th-29th	Available at Camp Sessions ○ March 14-18th ○ May 31st-June 3rd ○ July 25th-29th
FEEs Monday – Friday, 9am-4pm camps Cost for child: $250 1:1 staffing (if available): $100	FEE: Free if your child is attending camp (including lunch and snack) $80 if attending parent training without a child attending camp (including lunch and snacks): $80	Horseback riding with a NARHA certified instructor and trained camp staff supporting your child while riding Cost: $25 per ride Maximum number of rides: Week-long camps: 2 per wk
Camp Date Desired:	Attending Parent Training:	Number of Riding Sessions:

NATURE OF DISABILITY

(Check all that apply)

- ❑ Cerebral Palsy
- ❑ Spina Bifida
- ❑ Autism
- ❑ Asperger's Syndrome
- ❑ Epilepsy/Seizure Disorder
- ❑ Genetic/Chromosomal
  - ❑ Down Syndrome ❑ Other:
  - ❑ Fragile X
- ❑ Intellectual Disabilities
  Level: ❑ mild
- ❑ moderate
- ❑ Severe/profound
- ❑ Attention Deficit Disorder/ADHD
- ❑ Learning/Developmental Delay

- ❑ Speech-Language/Voice Dysfunction
- ❑ Social/Psychological
- ❑ Central Nervous System Injury/Disorder
- ❑ Multiple Sclerosis
- ❑ Behavior Disorders
- ❑ Spinal Cord Injury
  - ❑ Quadriplegic
  - ❑ Paraplegic
  - ❑ Other
- ❑ Visually Impaired
  - ❑ Partial
  - ❑ Total
- ❑ Hearing Impaired
  - ❑ Partial
  - ❑ Total

- ❑Orthopedic Impairment(s) at Birth
- ❑ Postural Disorders
- ❑ Heart, Circulatory, Respiratory Defect
- ❑ Asthma
- ❑ Psychosis
- ❑ Peripheral Nerve Injury/Disorder
- OBleed ing/Clotting disorders
- ❑ Skin and Cellular Tissue Disorder
- ❑ Muscular Dystrophy
- ❑ Allergic/Metabolic/Nutritional Diseases
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Other Disabilities (please list):

GENERAL BACKGROUND

MOBILITY: ❑ Walks independently ❑ Uses Crutches ❑ Uses Walker Mobility
❑ Uses wheelchair (manual): can camper push self? Yes No
❑ Uses wheelchair (power)

TRANSFERS ❑ No assists needed ❑ Can camper bear weight when standing? Yes No
❑ Needs assistance (explain transfer):

ASSISTIVE DEVICES ❑None ❑ Helmet ❑ AFO's ❑ Prosthesis
❑ Oxygen Machine ❑ Glasses ❑ Hearing Aid ❑ Other:

COMMUNICATION Does camper have difficulties expressing thoughts or wants? Yes or No
Please explain:____

Does camper use the following devices?
❑ Facilitated Communication ❑ Communication board ❑ Sign language
❑System of gestures (please describe):________________________

PERSONAL CARE

Eating Assistance:
❑ No assistance needed ❑ Partial assistance needed ❑ Total assistance needed
❑ Special utensils Please provide details:____________________________

Diet:
❑ Normal ❑ Chopped food ❑ Blended/pureed ❑ Low calorie ❑ Low salt
❑ Diabetic ❑ Special diet *Attach list of special diet so we may determine if we can meet applicant's needs.
❑ Food allergies(list): ____

Restroom Assistance:
❑ Always ❑ Sometimes ❑ Needs reminders ❑Incontinent
❑ Needs assistance ❑ On a schedule: if yes please describe _______________
❑ Uses disposable undergarments

Dressing Assistance:
❑ Partial Assistance ❑ Total Assistance ❑ Needs help with (belt, zipper, buttons, shoes)

HEALTH INFORMATION AND RESTRICTIONS

Please list any medications applicant uses:____

Seizures: ❑ Yes ❑ No Type Frequency

Describe any warning signs (aura) before seizures

* If camper is prescribed seizure medication they **MUST** bring the medication to camp.

Allergies: ❑ None ❑ Hay Fever ❑ Poison Ivy ❑ Insect Stings
❑ Asthma ❑ Penicillin ❑ Other:

Describe allergic reactions

Please summarize applicant's medical history:____
____

Has applicant ever required any psychiatric treatment/counseling or hospitalizations? ❑ Yes ❑ No Please summarize (include dates): :___
____

Does applicant have a shunt? ❑ Yes ❑ No List special instructions:____

Does applicant menstruate? ❑ Yes ❑ No

Special treatment for cramps?

List feminine products used:__________________________Do they need assistance with products: ❑ Yes ❑ No

Please list any activities the participant may NOT participate in or attach precautions or special instructions for routine camp activities: ______
____

SOCIAL BACKGROUND

School/Place of Employment:______________________________________ Grade Level: ______________________________

Can applicant read? ❑Yes ❑No
Does applicant have any special behavior problems? ❑Yes ❑No

When do behavior problems occur?____

Describe effective methods to control difficult behaviors: ____
____

Please list any fears the applicant may have: ____
Please list any activities the applicant dislikes:____
What hobbies or activities does the applicant enjoy at home or school:____
Please add any other information you feel would be helpful in providing the best experience for the applicant at camp:

INSURANCE

Is the applicant covered by hospitalization insurance? ❑Yes ❑No

Carrier:____________________________ Policy or Group Number:________________________

Medicare Number:________________________ Medicaid Number:___________________________

A copy of Insurance/Medicaid/Medicare card or Military ID card must accompany this application.
Please supply a copy of BOTH FRONT and BACK of the card.

Place copy of FRONT of Insurance Card here

P/ace copy of BACK of Insurance Card here

MEDICAL FORMS and PAYMENT

All 2009 Camp Registration Form, Medical Form and full payment must be received 15 days prior to the first day of the camp session the camper will be attending.

WAIVER AND RELEASE

The following section must be signed in ink by the adult applicant or legal guardian of the juvenile applicant before the application can be processed:

(1) This application has my approval. While Midnight Farms, a program of Community Living Opportunities (CLO) will take every reasonable precaution, it is agreed that Community Living Opportunities is not legally responsible for any accidents, incidents or injuries that may occur during the camp session, assumes no responsibility for applicant's personal property and is released from liability for any accident, incident or injury except as may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted by myself or physician.

(2) The below signed individuals agree to be photographed and/or videotaped by CLO while engaging in activities at Midnight Farm Camp with the understanding that said media may be used for the purpose of training and marketing. This includes but is not limited to printed material, web site material and promotional presentations.

(3) I attest that all information provided in these application materials including the application, medical examination summary, payment form and any supplemental items attached are true and correct to the best of my knowledge.

Legal Guardian/Parent:____ Date:____________

No camper will be discriminated against because of race, national origin, sex, age, religion or disability

MEDICAL EVALUATION and SIGNED STATEMENT

This form must be completed and signed by a health care professional and dated no more than 6 months prior to date of participation in order to participate in horseback riding during camp:
The following conditions, if present, may represent **precautions or contraindications** to therapeutic horseback riding. Therefore, please note if any of these conditions are present, and to what degree. **Please be as specific as possible so that we may best serve the participant's needs.** (Circle conditions that are present and add specifics below.)

Participant:____

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial instabilities
Scoliosis (>30, riding is contraindicated)
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis

Medical
Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia

Neurologic
Hydrocephalus/shut
Tethered Cord
Chiari ll Malformation
Hydromyelia
Paralysis due to spinal cord injury
Seizure Disorders

Secondary Concerns
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident

Behavior Problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

Other Condition(s) not listed above: ____

Please indicate specifics related to any existing health conditions, including degree of conditions such as scoliosis and osteoporosis, type of behavior problems, recent surgeries, type of seizures etc:

____

____

____

____

For participants with Down Syndrome

Please note:
Due to the nature of equine activities, including horseback riding, individuals diagnosed with Downs Syndrome cannot be accepted for participation without proof of a <u>negative</u> diagnostic x-ray for Atlantoaxial Instability.

Please provide the following information:

a) Most recent cervical x-ray for AAI: [ ]Negative .....Date of x-ray __________________________

b) Annual cervical exam for AAI: [ ]Negative ... Date of Exam __________________________

Updated 2/16/2011

Does the participant have a health concern and/or surgeries in any of the following areas? If yes, please explain:

Auditory ____________________

Visual ____________________

Speech ____________________

Cardiac ____________________

Circulatory ____________________

Pulmonary ____________________

Neurological ____________________

Muscular ____________________

Orthopedic ____________________

Allergies ____________________

Learning Disabilities ____________________

Mental or Psychological Impairment ____________________

Other: ____________________

Please describe any concerns or special medical or physical precautions or adaptations needed:

____

____

____

____

____

____

HEALTH CARE PROVIDER'S STATEMENT

(Signature Required)

To the best of my knowledge, there is no reason why this person cannot participate in supervised equestrian activities, including horseback riding. However, I understand that the staff at Midnight Farm will consider the medical information I have provided to determine their ability to meet the individual's existing health conditions, precautions and requirements.

Health Care Provider ____________________ **Title** ____________________

Office Address: ____________________ **Phone:** ____________________

REQUIRED:

Health Care Provider Signature ____________________ **Date:** ____________________