

CAMP ABILITY®
SPINA BIFIDA ASSOCIATION OF ILLINOIS
8765 W. Higgins Rd., Suite 403
Chicago, IL 60631
773-444-0305; FAX 773-444-0327

***Camp Applications are due by June 5th, 2009.** Campers will be accepted on a **FIRST COME FIRST SERVED** basis, based on **COMPLETE** applications. In-state applicants will be given preference until June 5th, at which point, campers who have turned in completed out-of-state applications will be accepted over incomplete in-state applicants. T-shirt sizes are not guaranteed for campers turning in paperwork after June 5th.

REGISTRATION FEE: A non-refundable required fee of \$100 must be submitted with this application. Camper families are asked to contribute toward the cost of camp whenever possible or to call the SBA of IL office with names of agencies or local service organizations willing to be solicited for this purpose. The actual cost of Camp Ability for SBA of IL is approximately \$1,200 per camper. Please help defray these costs either by donation or by identifying funding sources. If the camper is on Public Aid, do not send any money.

Registration fee _____ Contribution _____ Total Enclosed _____

DEPOSIT FEE: Campers accepted to Camp Ability will be required to pay a \$100 confirmation fee. Families are encouraged to plan accordingly for these expenses. Please DO NOT send the \$100 confirmation fee until you receive the camper session confirmation. The confirmation fee must be sent directly to the SBA of IL office and is non-refundable except in the event of a medical cancellation.

Applicant's Name _____ Nickname _____
 Address _____ School _____
 City, State, Zip _____ Date of Birth _____ Age _____
 County _____ T-shirt size _____
 Phone Number _____ Sex: M F Race (optional) _____
 Illinois Department of Public Aid Case # (if applicable) _____
 (please enclose a copy of your Public Aid card)

Parent/Guardian Name(s) _____
 Address _____ Home Phone _____
 City, State, Zip _____ Work Phone (father) _____
 Where parent/guardian can be reached (mother) _____
 during camp. Phone _____ (guardian) _____
 Location: _____ Health Insurance Co. and Policy # _____

Parent/guardian Place of Employment _____ Emergency Contact – other than parent (available during camp)
 Firm _____ Name _____
 Address _____ Address _____
 City, State, Zip _____ City, State, Zip _____
 Phone _____ Phone (w) _____ (h) _____

CAMPER PROFILE

This information will be used to determine whether the applicant's needs can be met adequately. If the applicant is accepted, this information will be used by camp personnel in best meeting the applicant's needs while at camp. Please be as open and complete in answering as you can. All information is confidential. Attach extra paper for answering if necessary.

Where does camper receive medical care for Spina Bifida? _____

List any secondary disabilities _____

Weight _____ Height _____ Primary Language _____

Hearing: Normal _____ Mild _____ Moderate _____ Severe _____ Global _____

Speech: Normal _____ Mild _____ Moderate _____ Severe _____ Global _____ If camper is unable to communicate by verbalization, what means does he/she use? Sign language _____ Gestures _____ Communication Board _____

Other, please explain _____

Vision: Normal _____ Impaired _____ Legally blind _____ Blind _____

Sleep: Sleeps well _____ difficulty getting to sleep _____ restless at night _____ does camper use a bed rail? _____

Please indicate session applied for:
 Ages 14-18 Aug. 9th - 15th _____
 Ages 7-13 Aug. 16th-22nd _____
 Ages 19+ Aug. 23rd-29th _____

Does camper want to go horseback riding? Yes _____ No _____ (Campers indicating "no" will remain at main camp for an alternative activity.)

Locomotion: Can camper walk? _____ Does camper have a walking schedule? _____ If yes, please describe _____

List any equipment or appliances used by the applicant (e.g. electric wheelchair, crutches, etc.)

Appliances used: How long should they be worn? _____

Does camper need assistance? Explain how _____

Can camper transfer alone? _____ Can camper control wheelchair by him/herself? _____

BEHAVIOR:

Has the applicant ever had a consistent behavior problem? _____ YES _____ NO

If yes, please describe _____

If yes, describe the best techniques for handling the problem _____

Does the applicant get along well with others? _____ YES _____ NO

If not, describe the problem and any remedies that work _____

TOILETING:

Explain assistance needed in all areas: _____

Bladder control - Daytime: Always _____ Some _____ Never _____

Nighttime: Always _____ Some _____ Never _____

Bowel control - Daytime: Always _____ Some _____ Never _____

Nighttime: Always _____ Some _____ Never _____

Toileting aids used _____ Day _____ Night _____

Commode _____ Colostomy _____ ILEO Appliance _____ Bedpan _____ Urinal _____ Catheter _____

If applicant uses a catheter, is assistance required? _____

Is constipation a problem? If yes, treatment used - Enema _____ Suppository _____ Laxative _____

Does applicant have a specific toileting schedule or bowel program? _____ Explain _____

Explain any assistance needed. _____

If applicant is a female, does she menstruate? _____ What type of sanitary protection does she use _____

EATING:

Can the applicant feed him/herself? _____ YES _____ NO

If assistance is needed, please explain _____

Please list any dietary restrictions or food allergies _____

GROOMING AND BATHING:

Check any personal areas where the applicant needs assistance: Dressing _____ Showering _____ Toileting _____

Menstrual period _____ Brushing teeth _____ Eyewear _____ Other _____

Describe assistance needed _____

PAST EXPERIENCE:

Does applicant have fears? _____ Explain _____

Is the applicant prone to wandering or running away? _____

Has applicant attended Camp Ability in the past? _____ What year(s) _____

Was applicant ever sent home or denied admission to camp? _____ If yes, explain _____

ADDITIONAL COMMENTS: _____

Due to the increased sensitivity for persons with Spina Bifida to latex, Camp Ability is a latex free camp. Please plan accordingly with your doctor(s) if you are currently using products that contain latex. PRODUCTS CONTAINING LATEX ARE PROHIBITED AT CAMP ABILITY.

PHYSICIAN CERTIFICATION
Camper physical must be performed after February 1st.

MEDICAL HISTORY:

CAMPER NAME: _____

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT		_____	_____	_____	_____	_____	_____
TD (tetanus/Diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
BCG		_____	_____	_____	_____	_____	_____

Has applicant had any of the following:

Measles Chicken Pox German measles Mumps Hepatitis

TB Mantoux Test Date of last test _____ Result: Positive Negative

Applicant's normal blood pressure _____ Applicant's normal temperature _____

Has there been any recent exposure to a contagious disease? YES NO

How would you assess applicant's current health GOOD FAIR POOR

List any chronic health problems (e.g. asthma, pressure sores, cough, etc.) and treatments of which the medical personnel should be aware _____

Is the applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B? _____ If yes, was a lab test conducted to determine the presence of antibodies? _____ Were antibodies present? _____

Is the applicant a carrier of any other infectious condition? _____ If yes, please explain _____

ALLERGIES:

Does the applicant have any known allergies YES NO If yes, describe the allergies _____

SEIZURES:

Does the applicant have seizures? YES NO If yes, answer the following: Current status (i.e. active, controlled) _____ Type of seizure _____ How often _____ Duration _____ Date of last seizure _____

Describe reactions before, during and after seizure _____

MEDICATIONS:

Please list all prescribed medications taken: _____

Medication charts will be mailed to campers along with their acceptance package as applications are approved.

RESTRICTIONS:

Has the applicant been hospitalized or treated in an emergency room recently? _____ If yes, please explain: _____

Are there any physical conditions, past operations, or injuries, which should restrict applicant's camp activities?

If yes, explain _____

Please check any restricted area: Swimming _____ Athletics _____ Overnight camping _____

Horseback riding _____ High ropes/zip line _____ Other _____

Please list any dietary restrictions _____

MEDICAL CONSENT

PHYSICIAN CONSENT AND SIGNATURE: (must be verified after February 1st)

When seen by me on this date, the above named applicant was free from any contagious or infectious disease or condition and is capable of participation at camp.

Signed _____

Physician's Name _____

Address _____

City, State, Zip _____

Date _____

Office Phone _____

Emergency Phone _____

Date of last physical exam _____

Must be after February 1st



Camper's Name: _____

Emergency Contact Phone Number: _____

****A PHYSICIAN'S SIGNATURE MUST BE INCLUDED ON THIS FORM****

Please check how the camper usually takes his/her medication? With drink In food Other _____

ALLERGIES: _____

Medications (Please print and include medication name and dosage to be given)	Su	M	T	W	Th	F
Breakfast (8:30am)						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Lunch (12:30pm)						
1.						
2.						
3.						
4.						
Dinner (5:30pm)						
1.						
2.						
3.						
4.						
5.						
Bedtime (8:30pm)						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Physician's Name: _____ Physician's Phone: _____

Physician's Signature: _____ Date: _____

**SPINA BIFIDA ASSOCIATION OF ILLINOIS
CAMP ABILITY®
8765 W. Higgins Rd., Suite 403, Chicago, IL 60631**

Parent/Guardian and Applicant agreement, consent and release:

Please read this section carefully, and be aware that in signing up and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries or loss or property damage that you (or your child) might sustain arising in any manner out of this program or the use of the facilities or equipment. This section must be filled out and signed by each participant and their parent or they will not be allowed to participate or use the facilities or equipment.

Photographic Release - In consideration of the furtherance of the purpose of the Spina Bifida Association of Illinois, Spina Bifida Camp Ability®, Jewish Council for Youth Services (JCYS), Centegra Northern Illinois Medical Center, I hereby grant permission to the same, to their officers, agents, and employees to take photographs or video of me (or my child) and to use my name (or my child's) in connection with any and all such photographs and in connection with any news release or story, and further, to use and distribute for publication any and all such photographs, video, news releases, and stories for any purpose they may deem proper. In granting such permission, I hereby relinquish any right, title and interest I may have in such photographs, video, new releases, and stories and grant the Spina Bifida Association of Illinois, Jewish Council for Youth Services (JCYS), Centegra Northern Illinois Medical Center, the right to use these products.

Acknowledgment of Risk or Injury Clause - As a participant in the program I recognized the risk and acknowledge that there are certain risks of physical injuries, including death, damages, property damage, or loss which I (or my child) may sustain as a result of participating in any and all activities connected with such program, or the use of the facilities or equipment.

Waiver of Claim for Injury Clause - I, on my behalf and on behalf of my child, agree to waive and relinquish all claims that I (or my child) may have for injuries or damages, as a result of participating in the program or using the facilities or equipment, against the Spina Bifida Association of Illinois, Camp Ability, Jewish Council for Youth Services (JCYS), Centegra Northern Illinois Medical Center, and their officers, agents, servants, employees, and affiliates.

Release from Liability Clause - I, on my behalf and on behalf of my child, do hereby fully release and discharge the Spina Bifida Association of Illinois, Camp Ability, Jewish Council for Youth Services (JCYS), Centegra Northern Illinois Medical Center, agents, servants, employees, and affiliates from any and all claims for injuries, including death, damages, property damage, or loss which may have or which may in the future accrue to me (or my child) on account of participation in the program or use of the facilities or equipment.

Indemnity and Defense Clause

A. I, on my behalf and on behalf of my child, further agree to indemnify and hold harmless and pay defense costs and defend the Spina Bifida Association of Illinois, Camp Ability, Jewish Council for Youth Services (JCYS), Centegra Northern Illinois Medical Center, and their officers, agents, servants, employees, and affiliates, from any and all claims resulting from injuries including death, damages, property damage, or loss sustained by me (or my child) and arising out of, connected with, or in any way associated with the activities of the program or the use of the facilities or equipment.

B. The undersigned does consent that photographs, video and/or motion pictures may be taken of the above applicant during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, publicity releases and/or other media.

C. The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital.

The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health and safety at camp.

The undersigned further agrees to pick up the camper immediately upon being notified of such termination. If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present **written** authorization from the undersigned.

I do hereby authorize (name, address and phone) _____
_____ to pick up the camper.

_____ (camper name) has my permission to participate in horseback riding and the high ropes course and zip line should it be offered.

Date _____

Legal signature _____

Both parents or guardians must sign

Please print camper name

Camper signature

TO BE FILLED OUT BY CAMPER:

GOALS YOU WOULD LIKE TO WORK ON DURING INDEPENDENCE SESSIONS

(Please include a minimum of two goals)

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE FILLED OUT BY PARENT/GUARDIAN (if applicable):

GOALS YOU WOULD LIKE TO SEE YOUR CAMPER WORK ON DURING INDEPENDENCE SESSIONS
(Please include a minimum of two goals)

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE FILLED OUT BY CAMPERS AGE 18 AND OVER:

I, _____, understand that as a camper at Camp Ability, I am agreeing to participate in camp activities, respect curfew, and refrain from inappropriate behavior, especially regarding my personal relationships with others. If my behavior becomes a problem, I realized that it may limit my participation in future sessions of Camp Ability.

Signature _____ Date _____