



2016 WINTER/SPRING RESPITE APPLICATION

Mail applications to: Indian Trails Camp, 0-1859 Lake Michigan Dr. NW, Grand Rapids, MI 49534. Or Fax to: 1 (616) 677-2955. Email: info@indiantrailscamp.org

CAMPER INFORMATION

CAMPER'S NAME: Last First Middle

ADDRESS: Street City State Zip

COUNTY: BIRTH DATE: Male Female

PHONE: Home Work Cell Accept Text Messages

ETHNIC BACKGROUND (optional): HAS CAMPER ATTENDED ITC BEFORE?: Yes No

EMAIL ADDRESS:

PRIMARY CONTACT Parent Guardian Camper Other Authorized Pick Up

ADDRESS (if different): street city state zip

PRIMARY PHONE: Home Work Cell Accept Text Messages

ALTERNATE PHONE: Home Work Cell Accept Text Messages

EMAIL ADDRESS:

SECONDARY CONTACT Parent Guardian Camper Other Authorized Pick Up

ADDRESS (if different): street city state zip

PRIMARY PHONE: Home Work Cell Accept Text Messages

ALTERNATE PHONE: Home Work Cell Accept Text Messages

EMAIL ADDRESS:

ALTERNATIVE CONTACT #1: Authorized Pick Up

PRIMARY PHONE: ALTERNATE PHONE:

ALTERNATIVE CONTACT #2: Authorized Pick Up

PRIMARY PHONE: ALTERNATE PHONE:



## SESSIONS

	WINTER/SPRING RESPITE DATES & THEMES	DATES
	<b>January 29-31, 2016: "Vegas Vacation"</b> Come travel to Las Vegas with us! There we will see great talent and play fun games.	2 Days
	<b>February 12-14, 2016: "Winter Wonderland"</b> Join us this weekend as we celebrate with our fourth annual Snowball Dance.	2 Days
	<b>February 26-28, 2016: "Myth Busters"</b> We are going to crack some myths this weekend as we play trivia and other brain busters.	2 Days
	<b>March 11-13, 2016: "March Madness"*</b> A fun weekend of basketball and fun competitive spirit. We may also throw in some green for St. Patty's Day!	2 Days
	<b>April 1-3, 2016: "Spring has Sprung"</b> Ready for spring? We are! Let's enjoy all that spring brings, including a Spring Break Carnival!	2 Days
	<b>April 8-10, 2016: "Treasure Island"**</b> If you love islands and treasure hunts, you better make it to this fun weekend as we work to find buried treasure!	2 Days
	<b>May 6-8, 2016: "Cinco de Mayo"</b> As we wrap up our respite season we will be celebrating Cinco de Mayo ITC style with Mardi Gras fun festivities	2 Days

Dates with a \* are for children (under 18) and adults. All other dates are for adults (18+) only.

*Check in times for respites are 3:00 p.m.-5:00 p.m. Pick up time is 11:00 a.m.-12:00 p.m.*

If any of the following forms were completed as part of the 2015 summer camp application, they should only be completed again IF there are changes to the information provided previously.

**EXCEPTION:** Third party payment forms and scholarship applications must be filled out each "season" if a third party will be paying all or a portion of the camp fee, OR if you are applying for a new scholarship.

A confirmation will be sent upon receipt of a completed application packet, including a scholarship application, if applicable.



# FINANCIAL FORM

**CAMPER NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_

<b>1. Select sessions to attend</b>
January 29-31
February 12-14
February 26-28
March 11-13
April 1-3
April 8-10
May 6-8

**2. Check the appropriate level below**

<b>LEVEL 1</b>	Minimal Dependence	\$254 (2-day)
<b>LEVEL 2</b>	Moderate Dependence	\$372 (2-day)
<b>LEVEL 3</b>	Complete Dependence	\$512 (2-day)

*If at any time after receipt of this form and camper application, the Camp Director and/or Health Director find the camper to require a different level of care than indicated, Indian Trails Camp reserves the right to change the level and fee accordingly. The camper and/or family will be notified if such change occurs.*

**3. Based on the Level Determination, complete the following calculations.**

**# OF SESSIONS:** \_\_\_\_\_ **X SESSION RATE: \$** \_\_\_\_\_ **= TOTAL DUE: \$** \_\_\_\_\_  
 Credit Card (complete part 4B)    Check    **#:** \_\_\_\_\_ **- DEPOSIT: \$** \_\_\_\_\_  
**= BALANCE DUE: \$** \_\_\_\_\_

I have a financial need and request scholarship funding (complete 4 below AND a scholarship application)

**3. Complete A, B, or C to indicate source of payment. If a scholarship is requested and granted, that amount will be deducted from the indicated payment option.**

**A. PARENT/GUARDIAN OR SELF WILL PAY BALANCE INCOMING DAY OR** \_\_\_\_\_ **EVERY** \_\_\_\_\_

**B. CREDIT CARD**    Visa    Mastercard    Discover    **SECURITY CODE:** \_\_\_\_\_

**CARD #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **EXP. DATE:** \_\_\_\_\_ / \_\_\_\_\_

**NAME AS IT APPEARS ON CARD:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**CARD BILLING ADDRESS:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**C. BILL ORGANIZATION**    **NAME OF ORGANIZATION TO BE BILLED:** \_\_\_\_\_

**CONTACT PERSON** (e.g. supports coordinator, case manager): \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **SEND BILL:**    before session    after session

**EMAIL** (if invoice may be emailed): \_\_\_\_\_ **AMT. TO BE PAID: \$** \_\_\_\_\_



# CAMPER INFORMATION

**CAMPER NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_ Male Female

**SESSION(S):** \_\_\_\_\_ **NICKNAME, IF ANY:** \_\_\_\_\_

*Check all applicable:*

**DISABILITY:**

- Cerebral Palsy
- Muscular Distrophy
- Spina Bifida
- Multiple Sclerosis
- Rheumatoid Arthritis
- Epilepsy
- Arthrogryposis
- Osteogenesis Imperf.
- Visual Impairment
- Autism/ASD
- Down's Syndrome
- Congenital Anomolies/Birth Defects: *Explain in detail*
- \_\_\_\_\_
- CHI (Closed Head Injury)
- Mental Impairment
  - Mild (Cognitive Impairment)
  - Moderate
  - Severe
- Other *(please explain)*
- \_\_\_\_\_

**CABIN MATE REQUESTS:**

*Please list any requests you have for cabin mates. We will do our best to accomodate your request.*

1: \_\_\_\_\_

2: \_\_\_\_\_

**COMMUNICATION:**

- No communication difficulties
- Verbalizes, may be difficult to understand
- Non-verbal, yes/no responses only

*Explain*

*Explain communication board or system*

*Additional helpful information*

**GENERAL HEALTH INFORMATION:**

Does camper have seizures? Yes No  
*Frequency*

*Please describe the seizures, including length and severity*

*Common signs/conditions of seizure*

Does the camper have allergies? Yes No  
*If yes, please explain agent and reaction in detail*

Is the camper allergic to service dogs? Yes No

**SPECIAL EQUIPMENT THAT CAMPER WILL BE BRINGING TO CAMP:**

**AMBULATION:**

- Crutches Walker
- Wheelchair Elec. Wheelchair
- Scooter Other

**OTHER:**

- Hoyer Lift Toilet Commode
- Communication Board Helmet
- Pace Maker Other

**EATING:**

- Special Cup Special Dish
- Plate Guard Special Utensils
- Other

**BRACING:**

- AFO Hand Splint
- Other



## ACTIVITIES OF DAILY LIVING

### EATING:

- Independent
- Needs only food cut and plate set
- Must be fed

### AMBULATION:

- Walks
- Independent
- Needs assistance (*describe*):

Depends on mobility device (*describe*):

### DRESSING & UNDESSING:

- Independent
- Need assistance with fine motor skills
- Total assistance

### PERSONAL CARE INFORMATION:

Check any which camper will need assistance with

- Showering
- Shaving
- Teeth-brushing
- Personal care: menstrual cycle

### TOILETING

- Wears briefs
- Independent
- Needs assistance (*describe*):

Special bowel treatment/program (*describe*):

How often does camper have bowel movements?

### TRANSFERS:

- Approx. weight: \_\_\_\_\_
- Independent
- Can bear weight for pivoting
- Must be lifted

Precautions that should be taken, if any:

### BEHAVIOR NEEDS\*:

Does camper have any behavior problems?      Yes      No

If yes, please describe:

Description:	Frequency:
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

How might we best accommodate these behavior problems?

### ADJUSTMENT TO CAMP:

Any fears? If so, please explain:

### OTHER

Anything else you would like us to know?

\*For information on our behavior policy, please see our website.



## LEVEL DETERMINATION

### LEVEL 1 (1:3)

Campers are provided one direct care counselor per three level 1 campers.

Level 1 is for campers who are able to perform most of their ADL's (Activities of Daily Living) independently.

Campers in this level take between 0-4 medications per day and do not have any current ongoing medical concerns.

Camper is independent with eating, or requires some verbal prompts and/or minimal physical assistance (e.g. cutting up food).

Camper is independent with hygiene needs, or may require some verbal prompts to ensure completion or thoroughness.

Camper is independent with toileting, or requires minimal verbal prompts.

Camper is independent with practicing coping skills and staying focused on task at hand, or requires minimal verbal prompts or redirection.

### LEVEL 2 (1:2)

Campers at this level are served with one direct care counselor per two campers.

Level 2 campers require some physical assistance but are independent in other areas of care.

Camper in Level 2 may not exceed 8 medications per day, and they have minimal medical concerns.

Camper may require minimal physical assistance with accessing food at meals, and/or requires specialized diet/nutrition (e.g. pureed food).

Camper may require minimal physical assistance with hygiene needs to ensure completion or thoroughness.

Camper may require minimal physical assistance (e.g. wiping) with toileting.

Camper may require verbal prompts or redirection with practicing coping skills and staying focused on the task at hand.

Camper may be dependent on a mobility device (e.g. walker, cane, etc.) but is able to use this primarily independently.

### LEVEL 3 (1:1)

Level 3 is reserved for campers who need on-to-one assistance the majority of the time due to medical or behavioral situations.

Medications may exceed 8 per day.

Campers who require medical treatments such as feeding tubes and severe seizure monitoring are automatically Level 3.

Camper may require full assistance with accessing food at meals.

Camper may require full assistance with most or all hygiene needs.

Camper may require full assistance with toileting, including transferring, diapering, and wiping.

Camper may require verbal prompts and redirection with practicing coping skills and staying focused on the task at hand most to all of the time.

Camper may be dependent on a mobility device (e.g. manual/electric wheelchair, scooter, etc.) at all times, and may be independent with using it or need assistance.

Camper may be a flight risk.



# INSURANCE FORM

**CAMPER NAME:** \_\_\_\_\_

Select sessions to attend
January 29-31
February 12-14
February 26-28
March 11-13
April 1-3
April 8-10
May 6-8

**\*IMPORTANT:** Indian Trails Camp, Inc. does not carry medical/accident insurance for campers. It is the responsibility of the camper/guardian to obtain adequate insurance coverage for any medical needs, including accidents.

**I UNDERSTAND THE ABOVE:** \_\_\_\_\_

*Signature of parent/guardian or adult camper*

**IS THE CAMPER COVERED BY MEDICAL INSURANCE?:**    Yes    No

If yes, please list the camper's health insurance carrier (examples: Blue Cross, Medicare, PPOM, etc.)

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

**POLICY NUMBER:** \_\_\_\_\_

**CONTRACT NUMBER:** \_\_\_\_\_

**CARD HOLDER'S NAME:** \_\_\_\_\_

**ADDITIONAL INFORMATION:** \_\_\_\_\_

\_\_\_\_\_



# CAMPER PHYSICAL FORM

This form **MUST** be completed by a licensed physician on or after 2/1/2015. This form **MUST** be completed in its entirety and submitted at least 2 weeks prior to the session start date. It does not need to be mailed with the application.

**CAMPER NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

1. Applicant must be diagnosed with a physical or developmental disability, mental illness, Downs Syndrom, or autism.
2. Applicant must be capable of social interaction and participation in camp activities.
3. Applicant must be able to communicate needs through at least a yes or no response (e.g. eye blinks, headshake, use of communication board, etc.).

**PRIMARY DIAGNOSIS/DISABILITY:** \_\_\_\_\_

**SECONDARY DIAGNOSIS:** \_\_\_\_\_

## MEDICAL HISTORY:

Asthma/Respiratory problems

Diabetes Type: \_\_\_\_\_

Heart Defect                      Apnea

Kidney Disorder                Other

Date of last Tetanus shot (must be within 10 years): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Does the camper frequently suffer from any of the following? (check all applicable)

Headaches                      Sore Throat                      Ear Infections

Immunizations (check all that have been issued and provide immunization dates):

Diphtheria                      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Pertussis                        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Measles                         \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Polio                              \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Small Pox                        \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Rubella                         \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Does the camper have known communicable diseases?

Measles    HIV Positive

Chicken Pox

Hepatitis                      A                      B                      C

Other: \_\_\_\_\_

Allergies and Reaction:

## CURRENT

**HEALTH:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_

**OVERALL HEALTH CONDITION:** \_\_\_\_\_

Other information for health care staff, including treatments to be continued at camp, activity restrictions, medically prescribed meal plan, or dietary restriction while at camp:

**I have reviewed the camper's health history and discussed the camp program with the camper and/or parent/guardian. It is my opinion that the applicant is physically and emotionally fit to participate in the session at Indian Trails Camp (except as noted above).**

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Office Name & Phone #

\*Overnight summer campers must have a camper physical form on file that is dated by the physician after 9/1/15 or within 12 months of when the camper attends camp. For example, if the physical is dated 8/1/15 and the camper is attending a June 2016 session, we would not need an updated form.







## HEALTH CARE AUTHORIZATION

**CAMPER NAME:** \_\_\_\_\_

The medical facilities listed below are utilized by ITC. Please check the facility that you prefer be used for yourself or your child in the event of an emergency or need for additional medical treatment.

**FACILITY:**

Mercy Health (approximately 15 miles east of ITC in downtown Grand Rapids)

Spectrum Health (approximately 10 miles east of ITC in downtown Grand Rapids)

Metro Health (approximately 15 miles southeast of ITC near M-6 and Byron Center Ave.)

Other hospital: \_\_\_\_\_

Spectrum Health Occupational Services (non-emergencies)

No preference

I hereby give permission to Indian Trails Camp, which is licensed by the State of Michigan, to provide routine, non-surgical medical care; administer medications; order x-rays and/or routine tests; release any records necessary for insurance purposes; provide or arrange necessary related transportation for myself or my child; and to secure emergency medical and surgical treatment. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Indian Trails Camp management to secure and administer treatment, including hospitalization for the camper listed above, while attending Indian Trails Camp.

**NOTE 1:** In accordance with MCLA Act 116 of the Public Acts of 1973, as amended, and the rules for licensing camps, this authorization must be signed by the parent or guardian of a minor camper, unless there is religious objection.

**NOTE 2:** In accordance with MCLA Act 218 of the Public Acts of 1979, as amended, and the rules for licensing camps, this authorization must be signed by the authorized person of an adult camper, unless there is religious objection.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*



## GENERAL LIABILITY RELEASE

I understand that Indian Trails Camp (ITC) assumes no responsibility for injuries that I or my child may sustain as a result of my or my child's physical condition, or resulting from my or my child's participation in any activities, programs, exercise, or the use of any facility, equipment, or other activities organized or sponsored by ITC. I expressly acknowledge that I assume risk for any and all injuries and illnesses that may result. In consideration of the privilege of using ITC, I hereby voluntarily release and discharge ITC, its agents, servants, and employees from any and all claims for injury, death, loss, or damage that I or my child may suffer. I understand that ITC is NOT responsible for personal property lost or stolen while members and/or program participants are using ITC facilities or on ITC premises.

---

*Adult Camper or Parent/Legal Guardian*

---

*Date*

## PHOTO RELEASE

I understand that Indian Trails Camp (ITC) loves to take pictures of guests enjoying themselves during their stay at camp, and that the photos are often used in marketing and promotional materials. ITC has my permission to use any media of me or my child at camp for purposes of promoting or describing ITC programs.

\*\*If you prefer that photos of you or your child not be used, please let us know in writing prior to the camp experience.

---

*Adult Camper or Parent/Legal Guardian*

---

*Date*

