

Dear SuperCamp Participants and SuperCamp Families:

Welcome to the 2019, 6 week SuperSchade’s Summer Camp! As you prepare for an exciting summer camp experience with SuperSchade’s, please find in this letter important information regarding our application process, camper admission and camp procedures. Please understand that we cannot guarantee a slot if we do not have your completed application and non-refundable Application Fee. Spaces are limited and will fill up quickly, so please get your completed application into us as soon as possible. We understand it may take time to schedule a doctor’s visit to complete the Medical/Physical History form. If this is the case, please communicate that with us and we will make accommodations. All Medical/ Physical History forms must be received at least 1 week prior to attending camp.

The 2019 6 week SuperCamp Application is available online at www.SuperSchades.org. If you do not have access to the internet, your county case worker or resident home provider can access the information for you. We will be glad to e-mail a copy to you but we will not be mailing out or faxing any applications.

All sections of the application, including Individual Service Plans, Medication Administration Record (MAR), and Medical/Physical Forms must be received **at least 1 week** prior to attending camp.

The most recent Medical Administration Record (MAR) must be mailed or e-mailed **1 week** prior to attending camp. WE WILL NOT ACCEPT A CAMPER IF THIS INFORMATION IS NOT COMPLETE AND YOU (PARENT/GUARDIAN or GROUP HOME) WILL BE RESPONSIBLE FOR ANY PENALTY FEES FOR NON-ATTENDANCE. We will work with you closely to see all sections are completed in a timely fashion.

CAMPER MEDICAL HEALTH – We make every effort to ensure our campers are not exposed to illness while at camp. To be admitted to camp, all campers must meet minimal health requirements:

* Temperature within the normal range for this individual
* Free from a communicable virus, disease or illness which poses a threat to others. Examples include MRSA, Influenza or Pink Eye.
* Blood Pressure within the normal range for this individual

If an individual fails to meet these requirements, our Camp staff and, if necessary a consulting physician will make a final determination as to the admission of the camper.

If you camper becomes ill or is injured while at Camp, the appropriate guardian will be notified and a determination will be made if the camper needs to be picked up from Camp. This is at the discretion of Camp staff.

CAMPER MEDICATIONS

* All prescription medications must be pre-packaged for the day by the pharmacy with the camper’s name, name of drug, dosage, and time to be taken. Any over- the counter medications, vitamins, herbal or homeopathic treatments must be in their original bottles.
* **Punch cards that have been cut will not be accepted**.
* Please provide only enough medications for one day of camp at a time.
* No extra medication will be accepted.
* All prescriptions will be dispensed according to the current doctor’s orders. Upon arrival at camp, the camper, parent/guardian, or direct care provider will be required to provide current and accurate medication orders as signed by a physician.
* If the camper is coming from a group home, a Medical Administration Record (MAR) must be received **2 weeks** prior to admission to camp. This is the responsibility of the guardian/ provider. A current doctor’s order must accompany any medication changes, including dosage, frequency or medication discontinuation. Your camper will not be accepted if this documentation is not in order.
* For campers living with a parent or guardian and not using an MAR, please fill out the medication list on the application and be sure to bring all medication in ORIGINAL bottles, or punch out cards with enough medication for the campers stay at Camp.
* If your camper does not have sufficient medication for the entire session, it will be the responsibility of the parent, guardian or group home provider to bring out the replacement.
* Medications will be dispensed at the following time unless otherwise specified by physician’s orders: Lunch (12:30 PM)

**CAMPER PHOTOS-** A recent photo must accompany your camper application. Camper photos allow our staff to recognize your camper upon arrival, allowing for a better transition to camp.

**FEES FOR CAMP-** Please complete the appropriate section of the Fee Form to ensure the correct individual or entity is billed for service. All outstanding balances must be paid in full prior to attendance.

**CANCELLATION POLICY-** Occasionally, a camper may need to cancel their registration due to illness. In such case, a doctor’s note must be submitted to SuperSchade’s Foundation. All other cancellations within 1 week of your camper’s scheduled arrival will be billed at full price. This payment is not Medicaid billable and is the sole responsibility of the camper, parent, guardian or group home provider. If it is determined the cancellation is due to group home provider error (i.e., late arrivals, missing paperwork, etc.), the group home provider will be billed for services. Please contact SuperSchade’s Foundation with additional questions regarding our cancellation policy.

**APPLICATION FEES:** A non-refundable application fee is due with all applications. This is a non-waiver service and cannot be billed to the waiver or your FRS account. The Application Fee for the 2018 6 week SuperCamp is $50.

**TRANSPORTATION:** SuperSchade’s Foundation **does NOT** provide any transportation to and/or from the camp. It is the responsibility of the parent/ guardian/ provider to provide ALL transportation to and from camp. \*If you are using TARPS for your campers, you MUST ensure you schedule times for drop off and pick up appropriately. Campers will not be allowed to sit for an hour at the hospital before camp begins at 9AM, and late pick up’s will be charged and invoiced to the parent/guardian\*

**CLOTHING:** To limit or avoid lost items, please LABEL all camper’s EXTRA clothing (if needed due to this being a day camp only), and any other items they may bring with them. Please leave expensive items at home so as not to have them lost or damaged. SuperSchade’s Foundation is not responsible for any items that are lost or damaged while at SuperCamp. If anything is forgotten it will be the parent or provider’s responsibility to bring the items to SuperCamp as soon as possible. Please remember that we do several activities indoors and outdoors where we suggest dressing your camper in “play clothes” as we do not want their clothing to become ruined.

**ADMISSION AND RELEASE OF CAMPER:** It is the responsibility of the contact person to make sure the appropriate people receive this information. Prior to check in, all sections of the application must be on file. This includes ISP, Behavior Plans, Medical/Health Forms, MARS and doctor’s orders for medication changes. Your camper will not be admitted to SuperCamp without a complete camper file. In such case, the group home provider will be responsible for any fees or penalties due to cancellation. We understand this is a lot of information. Feel free to call or email us if you have any questions or concerns.

**\*Your signature indicates you have read and understand our policies and procedures. Please return a signed copy to SuperSchade’s Foundation.**

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| Signature | Date |
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| Name | Title |

Please submit all application materials to:

SuperSchade’s Foundation

P.O. Box 599

Holland, OH 43528

Amanda Schade

419.410.5980

[MarketSuperSchades@gmail.com](mailto:MarketSuperSchades@gmail.com)

[www.SuperSchades.org](http://www.SuperSchades.org)

**SuperSchade’s 6 week SuperCamp Camper Participant Application**

Applicant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Nickname

Applicant Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City County State Zip Code

Applicant Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male \_\_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CONTACT INFORMATION:**

Primary Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Camper? \_\_\_\_\_\_\_\_\_\_\_

Direct Care Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City County State Zip Code

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (REQUIRED IF AVAILABLE):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should SuperCamp information be sent to Primary Contact, Camper Residence or e-mail? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SuperSchade’s Foundation prefers to send and receive documents via email when possible.**

**EMERGENCY AUTHORITY INFORMATION**

Name Phone Number

Primary Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist or Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: Yes\_\_\_\_\_ No\_\_\_\_\_

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy or Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid/Medicare #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby give permission to the medical personnel selected by SuperSchade’s Foundation to order x-rays, routine tests and treatment for me/my child/or ward, and in the event that parent/guardian cannot be reached in an emergency, I hereby give permission to the Physician selected by SuperSchade’s Management to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/my child/or ward as named above. This form may be photocopied for use out of camp.**

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

Signature of Parent/Guardian, Direct Care Staff Person or Adult Camper Date

**EMERGENCY TRANSPORTATION AUTHORIZATION**

I hereby give SuperSchade’s Foundation, Staff permission to transport (name) \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for emergency care, or to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for emergency dental care, or to the nearest available source of assistance.

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

Signature of Parent/Guardian, Direct Care Staff Person or Adult Camper Date

**Does your Camper have a Do Not Resuscitate Order? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_**

**(If yes, please attach all applicable documentation)**

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

Signature of Parent/Guardian, Direct Care Staff Person or Adult Camper Date

**CAMPER PROFILE**

The information you supply below is VERY IMPORTANT in caring for the campers and making group, camper/counselor assignments. PLEASE BE AS SPECIFIC AS POSSIBLE.

**Camper Information:**

Does Camper have a disability? \_\_\_\_\_\_\_ If yes, please continue to the rest of the questions.

Primary Disability:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Disability (ies):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Age Functioning Level: \_\_\_\_\_\_\_\_\_

**COMMUNICATION ABILITIES**

Normal Impaired Limitations

Hearing Ability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Ability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time-Concept \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Memory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other communication Difficulties \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uses communication Board/System YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verbalizes, may be difficult to understand YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Verbal – yes/no responses only YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Interactions YES NO**

Likes One-One Interaction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Likes Small Group Interaction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Likes Large Group Interaction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Has camper ever been away from home before \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Level of Supervision**

Likes Physical Interaction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Needs verbal prompting/cueing to understand and follow basic instructions YES NO

Understands and can follow basic instruction YES NO

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**Please include any additional information that may be used in caring for this camper**

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**Behavior and Behavior Management**

Camper has behavior supports listed in the ISP?

YES NO

Camper exhibits repetitive, difficult or dangerous (to self or others) behaviors at home or elsewhere?

YES NO

Camper exhibits observable antecedents (warning signs) before episodes or behavior problems?

YES NO

Please describe behaviors, emotional problems, triggers and possible resolutions to the camper's behaviors:

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

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Special behavior concerns and/or limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the Behavior Management Techniques used:

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Campers will not necessarily be excluded from this program because of any described behaviors. This information enables us to provide appropriate placement and to secure additional or specialized staffing if necessary, if we are able to. If camper requires 1:1 attention, special arrangements must be made by the parent(s)/guardian(s).1:1 support will NOT be provided by SuperSchade’s Foundation. Please report any behaviors appropriately and adequately.

**ACTIVITIES OF DAILY LIVING: Please be as specific as possible**

**EATING/DRINKING:**

\_\_\_\_\_Independent \_\_\_\_\_Needs food cut up

\_\_\_\_\_Needs Assistant \_\_\_\_\_Difficulty Swallowing

**DIET:**

\_\_\_\_\_Normal \_\_\_\_\_Knows Limits \_\_\_\_\_Low Salt

\_\_\_\_\_Low Calorie \_\_\_\_\_Diabetic

\_\_\_\_\_Special Diet Note: Please contact us to discuss.

\_\_\_\_\_Food Allergies: please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MOBILITY:**

\_\_\_\_\_Walks independently \_\_\_\_\_Walks: Needs Assist

\_\_\_\_\_Must be assisted on rough areas

\_\_\_\_\_Wheelchair: needs assistance at all times \_\_\_\_\_Wheelchair, but is independent in use

**TRANSFERS:**

\_\_\_\_\_Not applicable \_\_\_\_\_Can make transfers

\_\_\_\_\_Pivot Transfers \_\_\_\_\_Two person assistance \_\_\_\_\_Must be lifted

**DRESSES/UNDRESSES:**

\_\_\_\_\_Independent \_\_\_\_\_Needs assist with buttons/shoes/etc.

\_\_\_\_\_Needs total assistance \_\_\_\_\_Needs only some help

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| **Please include any additional information that may be useful in caring for this camper**  **SuperSchade’s Foundation**  **Insurance Waiver and Release of Liability**  **In consideration for participating in any way in SuperSchade’s Foundations recreation program, camps, related events and activities, the undersigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Agrees that prior to participating, I and/or the minor participant will inspect the facilities and equipment to be used, and if they believe anything is unsafe will immediately advise SuperSchade’s Foundation of such condition(s) and refuse to participate.  Agrees that I have personal responsibility to follow established safety rules & procedures to the extent that I participate in such activities. If I have questions about activity, I have the responsibility to consult the counselor. Acknowledge and fully understand that I and/or the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability, dismemberment and death, and severe social and/or economic losses which might result only from my own actions, inactions, the negligence of other campers, the rules of play, condition of the premises or any equipment used. Acknowledge and fully understand that there may be risks, beyond those mentioned in the foregoing, not known at this time or not reasonably foreseeable at this time.  Assume all of the foregoing risks and accept personal responsibility for any damages, claims, or losses following any loss of personal property, physical injury, permanent disability, dismemberment or death to myself and/or family member(s), including any minor children. Certify that myself and/or family member(s), including any minor children, are fully capable of participating in camp activities. Hereby forever release, waive, discharge, and covenant not to sue SuperSchade’s Foundation, its employees, volunteers, staff, board members, agents, successors, assigns, trustees, and/or members, its affiliated clubs, their representative administrators, directors, coaches, other participants, sponsoring agencies, sponsors, advertisers, heirs, and if applicable, owners, and leasers of premises used to conduce the event, all of whom are hereinafter referred to as "release’s", from demands, losses, claims or damages arising from injury to the above mentioned camper or his/her property caused or allegedly caused, in whole or in part, by the negligence of release’s or otherwise, that occurs during camping sessions or activities, in transit to or from the camp, or during any activity approved by release’s.  I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTANDTHAT I/WE HAVE GIVEN SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN, IT VOLUNTARILY.  **Participant's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Camper’s Signature Date  If participant is a minor and/or has a legal guardian, parent(s), and/or guardian(s), signature below is required:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian/Direct Care Staff Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Second Parent/Guardian/Direct Care Staff Signature Date  Note: If second parent signature is not possible, first parent/guardian certifies that the second parent/guardian has authorized to pursue this activity and second parent/guardian agrees to all items stipulated above.  **\*Campers will not be admitted without a signed Insurance Waiver and Release of Information on file.\***  **SuperSchade’s Foundation Photo Release**    I grant to SuperSchade’s Foundation, its representatives and employees the right to take photographs of me and my property in connection with the above- identified subject. I authorize SuperSchade’s Foundation, its assigns and transferees to copyright, use and publish the same in print and/ or electronically.  I agree that SuperSchade’s Foundation may use such photographs of me with or without my name and for lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.  I have read and understand the above:  Camper’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If participant is a minor and/or has a legal guardian, parent(s), and/or guardian(s), signature below is required:  Parent/Guardian/Direct Care Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Note: If second parent signature is not possible, first parent/guardian certifies that the second parent/guardian has authorized to pursue this activity and second parent/guardian agrees to all items stipulated above.    **SuperSchade’s Foundation 6 week SuperCamp Fee Form**  **In order for us to process your camp reservation, you MUST** **complete and return.**  **CAMP FEES (*Does Not Include Non-Refundable Application Fee)***  6 week SuperCamp Day Camp   * $1,275.00 (cash or check) \*if you are paying by credit card, there will be a 4% fee attached – an additional $51.00\*   **Non-Refundable Application Fee**   * $50.00 (cash or check) \*if you are paying by credit card, there will be a 4% fee attached – an additional $2.00\* * (must be included with application and is NOT part of the camp fee)   **Camper Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Payment in full enclosed Check #:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**    **OR**  **Charge Payment to: Master Card Visa Discover**  **Amt. of Charge: $\_\_\_\_\_\_\_\_Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_/\_\_\_\_\_**    **3 Digit Card Security Code:\_\_\_\_\_\_\_\_\_**    **Name as it appears on Credit Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Signature on account:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\*ALL CAMP FEE’S ARE DUE BY MONDAY, MAY 27th, 2019\***    **Please contact Amanda Schade to verify that the paperwork and information is complete and accurate. MarketSuperSchades@gmail.com or call 419.410.5980**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE of PERSON COMPLETING FORMS DATE  **Medical/Physical History**  **To Be Completed By A Medical Physician only!**  Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male:\_\_\_\_\_\_\_ Female:\_\_\_\_\_\_\_  Camper’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight: \_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_\_ Resp:\_\_\_\_\_\_\_\_\_\_\_  **Please indicate if camper has/had a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem**.  PROBLEM YES NO IF YES PLEASE DESCRIBE  Learning/Mental Impairment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Psychological Impairment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Auditory Impairment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hearing Aids: \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech Impairment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart Defect/Disease \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hypertension \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postural Hypertension \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PVD \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthma/COPD \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insulin Dependent \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kidney Disease/Impairment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bleeding/Clotting Disorders \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hemophilia \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HIV+ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hepatitis \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gastrointestinal Disorder \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pain \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Controlled \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Affected Areas \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Arthritis \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contractures \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fractures \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Location \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Healed \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spinal Column Injury \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date/Type \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Head Injury \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date/Type \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Joint Disease/Deformity \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Scoliosis \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Degree/Type \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hydrocephalus \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seizures: YES \_\_\_\_ NO \_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controlled: YES \_\_\_\_ NO\_\_\_\_  How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does Respiratory Difficulty occur? YES \_\_\_\_ NO \_\_\_\_ Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Camper’s behavior before and after a seizure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Skin Care: Any existing open areas? YES \_\_\_\_ NO \_\_\_\_  If yes, please describe size, location and care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Recent Illness/Injury: YES \_\_\_\_ NO \_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional Information: Please use this space to tell us any other medical information or recommendations pertinent to this individual’s participation in the SuperSchade’s Foundation’s programs:   |  | | --- | | Surgery: YES \_\_\_\_ NO \_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **Please circle item(s) that pertain to this camper. Write dates where indicated.**  **Allergies Females Only**  Food Yes No Has this person Menstruated? Yes No  Environment Yes No If no, is she aware of menstruation? Yes No  Drugs Yes No If yes, is her menstruation history normal? Yes No  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **IMMUNIZATION** DATES BOOSTER  Diptheria, Pertussis, Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tetanus, Diptheria, Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Oral Polio, (sabin) TOPV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Injectable polio (Salk) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Measles (hard, red Rubella) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tuberculin Test Given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chicken Pox (varicella) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Physicians Standing Orders**  The following nonprescription medications are used on an as- needed basis by the SuperSchade’s Foundation staff and unlicensed staff that has been certified by the Ohio Department of Developmental Disabilities to administer medications. Please select any item the individual **SHOULD NOT BE GIVEN**:  Acetaminophen (Tylenol) Do Not Give  Ibuprofen (Advil, Motrin) Do Not Give  Chloraseptic (Sore Throat Spray) Do Not Give  Hydrocortisone 1% Cream Do Not Give  Diphenhydramine Cream Do Not Give  Aloe Do Not Give  Topical Antibiotic Cream Do Not Give  Loperamide (Imodium) Do Not Give  Diphenhydramine (Benadryl) Do Not Give  Maalox Do Not Give  Bismuth Subsalicylate (Pepto) Do Not Give  Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MEDICATIONS (**attach additional sheets if necessary)  **Please complete only if the camper lives with a parent or guardian.** Those who live in a group home must submit the most recent MAR **2 weeks prior to day one of SuperCamp**. If there are any changes within those 2 weeks, physician orders must be completed and brought with the camper at check in.  Please fill in the following and remember to bring all medications in their original prescription bottle.  Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage Amount\_\_\_\_\_\_\_\_\_\_ Time of Day\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Directions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dosage Amount\_\_\_\_\_\_\_\_\_\_ Time of Day\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Directions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Campers will be participating in outdoor recreation and leisure programs while at camp, please list any medical, or limiting conditions we should be aware of:  **If personal supplies are necessary, it is the responsibility of the family to supply. SuperSchade’s Foundation will not supply these items.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SIGNATURE OF PERSON COMPLETING FORMS**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Adult Camper, Parent/Guardian, Direct Care Staff Date**  **Funding Sources Worksheet**  **(To be completed and turned in WITH the application. No application will be accepted, or even considered without this form.)**  **Where is your child’s funding coming from?**  **Funding Resource Name Amount of Funding**   1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** 2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** 3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** 4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** 5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_** 6. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**   **Camper Application Checklist**  **Please use this checklist as a guide in filling out the attached application.**   |  |  | | --- | --- | | DID YOU? | Yes/No (if no please indicate expected submission date) | | 1. **Signed Policy Acknowledgment Letter** |  | | 1. **Provide ACCURATE Emergency Contact Information** |  | | 1. **Complete all Campers Vital information (name, address, DOB, age, sex, phone number)** |  | | 1. **Include a recent photo of the camper** |  | | 1. **Sign the Emergency Authorization Permission Form** |  | | 1. **Include the Medical/Physical History Forms** |  | | 1. **Complete the Profile and Communications sections** |  | | 1. **Complete the Health History, Medications Form, Activities of Daily Living Forms/Sections** |  | | 1. **Thoroughly Read and Sign the Insurance Waiver Form** |  | | 1. **Complete and Sign the FEE FORM** |  | | 1. **Include a Non-Refundable Application Fee** |  | | 1. **Include the completed Funding Sources page** |  |   **NOTE: ANY INCOMPLETE APPLICATION MAY NOT BE PROCESSED. THIS COULD RESULT IN EITHER BEING PLACED ON OUR WAITING LIST OR THE LOSS OF A RESERVED PLACE IN OUR SUPERCAMP.**  Please keep a copy of this checklist and application for your records. If you have any questions, please call Amanda Schade at 419-410-5980 or email MarketSuperSchades@gmail.com. Thank you for your attention on all aspects of the camper application. We can’t wait to see your camper this summer! |
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