



We Prescribe Fun!

Elizabeth Turner Campbell, Founder

Family Retreat



What happens during a family week/weekend at camp?

Fun for the whole family!

Outdoor activities (horseback riding, archery, campfires, and much more).

Indoor activities (dances, swimming, climbing wall, bowling, billiards, woodshop and much more).

Who is eligible?

Any child and their immediate family members between the ages of 3 and 17 whom have an illness or condition The Center for Courageous Kids is serving during weekend. We request **only family members residing together** attend the Family Retreat unless special circumstances apply.

Accommodations:

Families will be housed together as a family unit. Each family will have their own sleeping quarters and bathroom. Healthy family meals will be provided. We may not be able to accommodate some dietary concerns or menu preferences. Some specialized diets may need to be provided by the family. Please contact The Office of Camper Recruitment if there is a specific dietary concern to determine if we are able to meet those needs or if you will need to provide food. If medical equipment is brought for the camper, **please bring a surge protector** that is clearly labeled with the child's name on it. Service dogs may be present during camp sessions. Please be aware in the event your child may have a fear of or allergies to dogs.

Medical coverage:

Medical personnel will always be available on site during summer camp and family retreats to provide services and support as needed to ensure a safe camp experience.

To apply:

Complete the family application. This includes:

- Family Retreat Application Form (may be completed on-line or mailed)
- Family Member Medical Form
- Courageous Camper Medical Form for each Courageous Camper (physician signature is required)
- Parental Waiver and Consent Form
- Copy of insurance card (front and back) for each person attending

Acceptance to camp is based on ability to provide medical support and number of applicants.



Our programs are made possible solely by donations. All donations are welcome, appreciated, and needed to continue serving families and children.



Return the completed application to: Center for Courageous Kids
Camper Recruiter
1501 Burnley Road
Scottsville, KY 42164
Fax: 270-618-2902

If you have any questions, please call the Office of Camper Recruiting at 270-618-2912.



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Family Retreat Application

Camp Session Requested:

Camp Date: _____

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★ Family Contact Person: _____ Relationship to Courageous Camper: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip: _____ Home Number:(____) _____

Work: (____) _____ Cell: (____) _____ E-mail Address: _____

Emergency Contact Person: _____ Relationship to Courageous Camper: _____

Home Number:(____) _____ Work: (____) _____ Cell: (____) _____



**Please list all family members attending including Courageous Camper:
(We request ONLY family members residing in the Courageous Camper's household attend.)**

Name	Relationship	Date of Birth	Male/Female
Parent/Guardian:			
Parent/Guardian:			
Courageous Camper:			
Family member:			
Family member:			
Family member:			
Family member:			

Please provide a copy (front and back) of the insurance card for each person attending camp.

What Children's Hospital do you use? _____

How did you learn about camp?

- Friends/family member
- Media
- School

- Courageous Kids Staff
- Website (specify): _____
- Hospital/Care Center (specify): _____

Organization Affiliation: (Example: BraveHearts, Muscular Dystrophy Assoc, FEAST, JA Foundation)

- _____ (write in name)
- None



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Family Member Medical Form

Please include every family member attending camp.

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Family member name:	List any medications family member takes on a regular basis:	Allergies (food or medication):	Medical/behavioral conditions or other notes:
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	
		<input type="checkbox"/> None <input type="checkbox"/> _____ _____	

****Narcotic (Schedule II) medications must be stored in the narcotic box in the Medical Center pharmacy or in a locked vehicle at all times. ****



Courageous Camper Medical Form

(Primary Treating Physician must sign)

This form is valid for one year from the physician's signature.

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Courageous Camper's Name: _____ Preferred name: _____

Age: _____ Birth date: ____/____/____ Male/Female Ethnicity: _____

Primary diagnosis: _____

Secondary conditions (if applicable): _____

No Allergies
 Food/Environmental Allergies: _____
 Medication Allergies: _____

Functions at what grade level: _____ Height: _____ Weight (lbs.): _____

Specialist Physician: _____ Office Number: (____) _____

Specialty: _____ City/State: _____

Please indicate if the camper has the following:

The Center for Courageous Kids does not bill insurance, information gathered for emergency use only

No medical insurance
 Medical Card
 Passport Medical Card (KY)
 Private Medical Insurance, specify name of insurance: _____

******* Attach copy of front and back of Medical/Insurance card. *******

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:

Activity restrictions

No Restrictions
 Self Limited Activities: _____
 No Vigorous Physical Activities

Dietary restrictions: _____

Enlarged spleen or liver: _____

Adaptive Devices

Wheelchair
 Walker/Crutches
 Hospital Bed
 Splint/Braces
 Artificial Limb
 G-Tube
 Ostomy
 Oxygen
 BiPaP
 Other: _____

Pull Ups/Diapers/Briefs

Enuresis (bedwetting)

Has started menstrual cycle (female only)

Service Dog – Service the dog provides for camper:

(We request a copy of up to date vaccinations including DA2PP, Rabies and Bordetella. Also include certification if available.)

**Child must bring all medications and supplies to camp.
Please list all medications including over the counter (OTC).**

Medication Name	Dosage	Times medication is given	How medication is given	Purpose of Medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

***** **Attach copy of Immunization Record for Courageous Camper.** *****

Exempt from immunizations for religious or medical reasons.

(If exempt, please contact the Office of Camper Recruiting for Statement of Exemption Form.)

Does this child have central venous catheter? YES NO

If yes, indicate type (i.e. broviac, portacath) _____

Please complete the information or lab values pertaining to illness/condition group that affects this child.

Labs: Please provide most recent lab findings if applicable for illness/condition.

Date of labs results: _____

H/H: _____

WBC: _____

Platelets: _____

ANC: _____

List any hospitalizations/surgeries **in the past year:**

1. _____ Date: _____

2. _____ Date: _____

Functionality Rating Scale (FRS) Scoring Instructions: Please indicate the level of instruction or ability for the child. Comments section to be used for further details or explanations.

Category	Item	Instructions	Comments
Self Function	Communication Ability	3 = Normal 2 = <i>slightly delayed</i> 1 = <i>markedly delayed</i> 0 = <i>incomprehensible/none</i>	
	Body Movement	3 = <i>normal movement</i> 2 = <i>limited movement</i> 1 = <i>severely limited movement</i> 0 = <i>no movement</i>	
Self Care Activities	Feeding Assistance	3 = <i>independent</i> 2 = <i>minimal</i> 1 = <i>partial</i> 0 = <i>complete assistance</i>	
	Toileting Assistance	3 = <i>independent</i> 2 = <i>minimal</i> 1 = <i>partial</i> 0 = <i>complete assistance</i>	
	Grooming/Showering Assistance	3 = <i>independent</i> 2 = <i>minimal</i> 1 = <i>partial</i> 0 = <i>complete assistance</i>	
Dependence on Others	Level of Functioning	3 = <i>completely independent</i> 2 = <i>independent in special environment</i> 1 = <i>moderately dependent</i> 0 = <i>totally dependent</i>	
Social Adaptability	Interaction with others	3 = <i>fully capable</i> 2 = <i>situational limitations</i> 1 = <i>extremely limited</i> 0 = <i>unable to engage with others</i>	
Total FRS Score: _____			

For Office Use Only:

Functionality Ranges			
Counselor: Camper Ratio HCP: Camper Ratio	1-9	10-15	16-21
	1:1	1:2	1:4
	1:10	1:20	1:30

Behavioral

When your child becomes angry, frustrated, or upset, what is his/her typical behavior and our best response?

How does your child interact in a group of children of the same age? _____

Special bedtime needs: _____

Can your child: (Applies to summer camp only)

Sleep in a room with other children? Yes No

Follow a structured schedule? Yes No

Take/follow directions? Yes No

Current stressful family situations:

Other comments: _____

Asthma/Allergies/Respiratory

Not Applicable

Respiratory Alterations

Requires suctioning

Frequency _____

Trach

CPT

Oxygen needs

Please indicate if camper has/had any of the following in the past year:

Systemic Corticoid Steroid Treatment

Exercise induced asthma

Comments: _____

Asthma Action Plan (**If checked, please attach**)

Known triggers

Describe: _____

Anaphylaxis reaction to:

Describe: _____

Airborne Allergy to:

Describe: _____

Due to asthma, within the last year, how many times has your child: N/A

Missed school? _____

Visited the ER or urgent care clinic? _____

Admitted to hospital? _____

Cancer

Not Applicable

Is this child:

Receiving active cancer treatment

Specify treatment regime needed while at camp (including lab work, scans, etc.):

In Remission. How long? _____

Long term side effects from treatment or illness

Describe: _____

Juvenile Arthritis/Lupus

Not Applicable

Remedies or Treatments used:

Stretching

Exercise

Heat

Splints

Other: _____

Seizure Disorder **Not Applicable**

Type of seizure:

- Partial
- Generalized
 - Convulsive
 - Non-convulsive

Seizures typically occur how often?

- Daily how many? _____
- Weekly how many? _____
- Monthly how many? _____
- Yearly how many? _____
- None in past year

Typical duration of postictal phase (after seizure): _____

Special situations that induce a seizure: _____

Heart **Not Applicable**

- Pacemaker/Defibrillator
- Heart Transplant
- Pulmonary Hypertension
- Decreased Ventricular Function
- On Coumadin
- Require Oxygen

If YES, type: _____

If YES, give date: _____

If YES, give treatment: _____

If YES, indicate: () RV () LV () SV

If YES, most recent PT and INR: _____

If YES, amount: _____ when: _____

Normal O2 Sats: _____

Blood Disorders **Not Applicable**

Type of Disorder

- Hemophilia A (Factor 8)
 - Hemophilia B (Factor 9)
 - Von Willebrand Disease
 - Other Bleeding Disorder
- Specify: _____

Child receives prophylactic infusions of factor.

Schedule: _____

Does this child self infuse?

- Yes With Assistance
- No Would like to learn
- Home Care Services

Contact Person: _____

Phone Number: _____

HTC Affiliation: _____

Diabetes **Not Applicable**

Frequency of blood glucose monitoring:

- Before meals/Bedtime (AC & HS)
- Every _____ hours
- Other _____

Symptoms of hypoglycemia: _____

Most recent HgA1C result: _____

Carb counting: _____

Insulin Pump

Child independent with pump

Child needs assistance with pump

Explain: _____

Insulin injections

Independent

Needs assistance

Explain: _____

Additional comments: _____

Sickle Cell **Not Applicable**

Indicate if any history of:

- Acute Chest Syndrome
- Delayed growth
- Anemia
- Dehydration as a stressor

- Extreme temperatures as a stressor
- Stress/Overexertion as a stressor
- Fatigue as a stressor

Prevention or treatment strategies: _____

Other situations that may cause a crisis episode:

Physical Disability/Cerebral Palsy/Spina Bifida/Muscular Dystrophy **Not Applicable**
(Including Brain Injury, Spinal Cord Injury)

Neurosurgeon: _____

Phone Number: (____) _____

Child has the following:

No Current issues

- Shunt
- Spinal Rods
- Vesicostomy
- Cecostomy
- MACE
- Bowel Incontinence

- Quadriplegia
- Paraplegia

Child requires:

- Assistance with standing
 - Assistance with turning in bed at night
- Frequency: _____

Describe program: _____

- Bladder Incontinence

Describe program/Catheterization schedule:

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 acknowledged that the camper, _____, is physically able to attend camp.

Date of last exam (*must be within 24 months*): _____

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 myself/my children to participate in any and all activities including but not limited to lifeguard supervised swimming, lifeguard supervised boating and fishing, guided horseback riding, and the rock climbing wall under supervision of certified instructors at The Center for Courageous Kids (“The Center”) unless otherwise specified on the **Family Medical Form** or **Courageous Camper Medical Form**. I recognize and acknowledge the inherent risks that these activities may present for me/my children.

I acknowledge that the possession or use of alcoholic beverages and illegal drugs are strictly forbidden. I understand the possession of any weapon (firearm, knife, explosives, etc.) is strictly forbidden on camp property.

I authorize The Center to release my demographic information to supporting affiliates who help with the cost of my child attending camp.

I acknowledge no family animals/pets will be allowed on the premises of The Center with the exception of service dogs.

I plan to bring a service dog to The Center for Courageous Kids.

Medical Consent

The Center will make every effort to contact me in the case of an emergency. I give my permission for The Center and its medical staff to administer any medications needed and to provide and arrange for any necessary medical treatment to myself/my children while at The Center, including onsite and offsite emergency care. I accept responsibility for the costs of all such medical treatment.

I decline medical care for my child and/or family.

Participation Release and Waiver

Because I acknowledge the risks of attending myself or allowing my children to participate, I agree to release and hold harmless The Center and its founder, trustees, directors, officers, employees, agents, affiliates, volunteers and medical staff (“Staff”) from any and all injury claims of any other nature which may result from my/my children’s participation at and travel to or from The Center. I agree to indemnify and hold The Center, its Staff and other children at The Center harmless from any and all liability caused by myself/my children, whether or not intentional.

Photography Release

In consideration of my/my children’s participation at The Center, and without any further consideration from The Center, I hereby grant permission to The Center and 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 Center. The Center may use my/my children’s name, likeness, voice and biographical material in connection with publication, promotion, exhibition and distribution of such material. 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.

I decline photography release for my child and/or family.

If you have questions, please contact The Office of Camper Recruitment at 270-618-2912 before signing.

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 myself/ my children.

Please list all dependent children that will be attending camp.

Child's Name: _____
Child's Name: _____
Child's Name: _____
Child's Name: _____
Child's Name: _____
Child's Name: _____

Parent/Guardian must sign. Signature represents legal authority for children listed above as well as for self. If both parents are attending camp each must sign.

Parent/Guardian (1) Print Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian (2) Print Name: _____

Parent/Guardian Signature: _____ Date: _____

Any other adult attending camp must sign (i.e. Grandparents).

Adult Family Member (1) Print Name: _____

Adult Family Member Signature: _____ Date: _____

Adult Family Member (2) Print Name: _____

Adult Family Member Signature: _____ Date: _____



IMPORTANT – The following items must be completed/provided:



- Family Retreat Application Form
- Family Member Medical Form
- Courageous Camper Medical Form for *each* Courageous Camper (physician signature is required)
- Parental Waiver and Consent Form
- Copy of insurance card (front and back) for each person attending