



**We Prescribe Fun!**

Elizabeth Turner Campbell, Founder

# Summer Camp

## What happens during a week at The Center for Courageous Kids camp?

- + Fun, Fun and more Fun!!
- + Outdoor activities (hiking, horseback riding, archery, campfires, and much more).
- + Indoor activities (dances, swimming, climbing wall, bowling, billiards, woodshop and much more).

## Who is eligible?

Any child between the ages of 7 and 15 whom has an illness or condition The Center for Courageous Kids is serving during the week.

## Accommodations:

Children will be housed with their selected group and counselor as a unit in a cabin. Each group will have their own private sleeping quarters and bathroom. Healthy 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. 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 camper application. This includes:

- Camper Application Form (may be completed on-line or mailed)
- 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 Courageous Camper
- Copy of Immunization Record for Courageous Camper (child with illness)

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 contact the Office of Camper Recruiting at 270-618-2912**



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# Courageous Camper Application

Camp Session Requested: \_\_\_\_\_

Camp Date: \_\_\_\_\_

Elizabeth Turner Campbell, Founder

## Please print.



Courageous Camper's Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Male

Female

T-shirt size (select one):

**CHILD**  SMALL  MEDIUM  LARGE  
**ADULT**  SMALL  MEDIUM  LARGE

*\*\*Supply dependent upon program*

Primary Diagnosis/Condition(s): \_\_\_\_\_



## Contact/Emergency Information:

Parent or Guardian Name: \_\_\_\_\_

Street Address \_\_\_\_\_ County: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Number: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax :(\_\_\_\_) \_\_\_\_\_



## Alternate Contact:

Name: \_\_\_\_\_ Relationship to Courageous Camper: \_\_\_\_\_

Home Number: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_



## How did you hear about camp?

- Friends/family member
- Media
- Hospital/Care Center (specify): \_\_\_\_\_
- Organization (specify): \_\_\_\_\_
- Website (specify): \_\_\_\_\_



# Courageous Camper Medical Form

**(Primary Treating Physician must sign)**

*This form is valid for one year.*

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Courageous Camper's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ethnicity: \_\_\_\_\_

Primary diagnosis: \_\_\_\_\_

Secondary conditions (if applicable): \_\_\_\_\_

- No Allergies
- Food/Environmental Allergies: \_\_\_\_\_
- Medication Allergies: \_\_\_\_\_

Functions at what grade level: \_\_\_\_\_ Height: \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Hospital of choice: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Primary Treating Physician: \_\_\_\_\_ Office Number: (\_\_\_\_) \_\_\_\_\_

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          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |
| Hearing         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |
| Teeth           | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |
| Skin            | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |
| Speech          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |
| Reading Ability | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Comments: _____ |

Please indicate and explain if the child has/uses any of the following:

- |  |   |
|--|---|
| Activity restrictions                                    | <input type="checkbox"/> Dietary restrictions: _____                    |
| <input type="checkbox"/> No Restrictions                 |   |
| <input type="checkbox"/> Self Limited Activities: _____  | <input type="checkbox"/> Enlarged spleen or liver: _____                |
| <input type="checkbox"/> No Vigorous Physical Activities |   |
| Adaptive Devices   | <input type="checkbox"/> Pull Ups/Diapers/Briefs                        |
| <input type="checkbox"/> Wheelchair                      | <input type="checkbox"/> Enuresis (bedwetting)                          |
| <input type="checkbox"/> Walker/Crutches                 | <input type="checkbox"/> Has started menstrual cycle (female only)      |
| <input type="checkbox"/> Splint/Braces                   | <input type="checkbox"/> Service Dog – Service dog provides for camper: |
| <input type="checkbox"/> Artificial Limb                 |   |
| <input type="checkbox"/> G-Tube                          |   |
| <input type="checkbox"/> Ostomy                          |   |
| <input type="checkbox"/> Respiratory Equipment           |   |
| <input type="checkbox"/> Other: _____                    |   |

**(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	4 = normal 3 = slight delay 2 = moderate delay 1 = incomprehensible 0 = none	
	Body Movement	3 = normal movement 2 = limited movement 1 = severely limited movement 0 = no movement	
Cognitive Ability for Self Care Activities	Feeding Assistance	3 = independent 2 = minimal 1 = partial 0 = complete assistance	
	Toileting Assistance	3 = independent 2 = minimal 1 = partial 0 = complete assistance	
	Grooming/Showering Assistance	3 = independent 2 = minimal 1 = partial 0 = complete assistance	
Dependence on Others	Level of Functioning	5 = completely independent 4 = independent in special environment 3 = mildly dependent 2 = moderately dependent 1 = markedly dependent 0 = totally dependent	
Social Adaptability	Interaction with others	3 = fully capable 2 = situational limitations 1 = extremely limited 0 = unable to engage with others	
Total FRS Score			

*For Office Use Only:*

Functionality Ranges			
Counselor: Camper Ratio	1-12	13-17	18-24
	1:1	1:2	1:4
HCP: Camper Ratio	1-12	13-17	18-24
	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?

\_\_\_\_\_

Bedtime routines: \_\_\_\_\_

\_\_\_\_\_

Current stressful family situations:

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

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

\_\_\_\_\_

How often does your child require close (one on one) supervision due to their condition? Please provide comments.

- All of the time: \_\_\_\_\_
- Some of the time: \_\_\_\_\_
- None of the time: \_\_\_\_\_

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

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

**Asthma/Respiratory**     **Not Applicable**

Classification:

- N/A
- Mild Intermittent (1)
- Mild Persistent (2)
- Moderate Persistent (3)
- Severe (4)

- Respiratory Alterations
  - Requires suctioning  
Frequency \_\_\_\_\_
  - Trach
  - CPT
  - Oxygen needs

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? \_\_\_\_\_

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

- Systemic Corticoid Steroid Treatment
- Known triggers  
Describe: \_\_\_\_\_
- Anaphylaxis reaction  
Describe: \_\_\_\_\_
- Exercise induced asthma  
Comments: \_\_\_\_\_
- Asthma Action Plan  
**If checked, please attach.**

**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**     **Not Applicable**

Remedies or Treatments used:

- Stretching                       Exercise
- Heat                                 Splints
- Other: \_\_\_\_\_

**Seizure Disorder**  **Not Applicable**

Type of seizure:

- Partial
- Generalized
  - Convulsive
  - Non-convulsive

Describe child's behavior after (postictal) a seizure:

\_\_\_\_\_

Seizures typically occur how often?

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

In general, what tends to induce a seizure? ( i.e. excitement, fatigue, etc.)

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

**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: \_\_\_\_\_

HTC Affiliation: \_\_\_\_\_

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: \_\_\_\_\_

**Diabetes**  **Not Applicable**

Frequency of blood glucose monitoring:

- AC & HS
- Every \_\_\_\_\_ hours
- Other \_\_\_\_\_

Symptoms of hypoglycemia: \_\_\_\_\_

\_\_\_\_\_

Most recent HgA1C result: \_\_\_\_\_

Carb counting: \_\_\_\_\_

Insulin Pump

Child independent with pump

Child needs assist with pump

Explain: \_\_\_\_\_

Insulin injections

Independent

Needs assist

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:

- Shunt
- Bowel Incontinence  
Describe program: \_\_\_\_\_
- Bladder Incontinence  
Describe program: \_\_\_\_\_
- Vesticostomy
- Cecostomy
- MACE

Catheterization frequency:

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

- Quadriplegic
- Paraplegic

Child requires:

- Assistance with standing
- Assistance with turning in bed at night  
Frequency: \_\_\_\_\_
- Head of bed elevated

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 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 medication 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, 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.

Please contact the Office of Camper Recruitment at 270-618-2912 before signing if you have questions.

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 my child.

Child's Name: \_\_\_\_\_

**Parent/Guardian must sign. Signature represents legal authority for child listed above.**

Parent/Guardian Print Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**IMPORTANT – The following items must be completed/provided:**



- Camper Application Form (may be completed on-line or mailed)
- 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
- Copy of Immunization Record for Courageous Camper