Family Retreat

Elizabeth Turner Campbell, Founder

What happens during a Family Retreat at The Center for Courageous Kids (CCK) camp?

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

Who is eligible?

Any child (5-17yrs) with a medical diagnosis, and immediate family members, is eligible to apply. We request that *only family members residing together in the same household* attend the Family Retreat unless special circumstances apply.

How are our lodging and meals provided?

Families will be housed together as a family unit. Each family will have their own sleeping quarters and bathroom. Healthy meals will be provided. We may not be able to accommodate some dietary concerns or menu preferences outside of the menu provided. Please contact the Office of Camper Admissions with questions.

How will my medical concerns be provided for?

Medical personnel will always be available on site.

What else do I need to know?

- If medical equipment is brought for your camper, **please bring a surge protector** that is clearly labeled with the child's name on it.
- Please be aware that **service dogs** may be present during camp sessions in the event that your child has a fear of or allergy to dogs.
- Acceptance to camp is based on CCK's ability to provide medical support and the pool of applicants.
- **The Camper Admissions Office will communicate with you by e-mail**. If no e-mail address is provided, documents will be mailed to you by U.S. Mail.

How do I apply?

Complete the camper application.

- Step 1: Submit a Family Retreat Application Form (may be completed on-line or in writing).
- Step 2: Courageous Camper Medical Form for each Courageous Camper (physician signature is required), plus Family Member Medical Form, Parental Waiver and Consent Form and copy of insurance card.
- Return the completed application by mail or fax to:

Center for Courageous Kids
Camper Admissions
1501 Burnley Road
Scottsville, KY 42164
Phone: 270-618-2912
Fax: 270-618-2902

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

Family Retreat Application

STEP 1

Please print clearly.

Today's Date: _____

CAMP SESSION REQUESTED: _____ **CAMP DATE:** _____

Courageous Camper's Name: _____

Birth date: ___/___/___ Age: ____

☐ Male ☐ Female

Mark one ethnic identity (*optional*):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities (*optional*):
☐ Asian
☐ American Indian or Alaska Native
☐ White
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American

Primary Diagnosis/Condition(s): _____

If your household receives SNAP, TANF, FDPIR please provide the case number: _____
(This information will only be used for the benefit of The Center for Courageous Kids to participate in the Summer Food Service Program through the U.S. Department of Agriculture (USDA) – All information will be kept CONFIDENTIAL).

Parent/Guardian Information:

Parent or Guardian Name: _____
Street Address_____ County _____
City_____ State _____ Zip _____ Country _____
Home Number: (___) _____ Cell Number: (____) _____
Work Number: (____)_____ Fax Number: (____) _____
E-mail Address: _____
Employer: _____ Job Title: _____

Alternate or Emergency Contact (outside the home):

Name: _____ Relationship to Courageous Camper: _____
Home Number: (____) _____ Work: (____) _____ Cell: (____) _____

How did you learn about camp?

☐ Friends/family member
☐ Media
☐ School
☐ Courageous Kids Staff
☐ Website (specify): _____
☐ Hospital/Care Center (specify):_____

Organization Affiliation: (Example: BraveHearts, EFI, Muscular Dystrophy Assoc., TMA)
(write in name): _____ or None

What Children's Hospital do you use? _____

Family Member Medical Form

Elizabeth Turner Campbell, Founder DATE: _____

Please list every family member attending camp.

We request ONLY family members residing in the Courageous Camper's household attend.

Name	RACE: (optional) Asian, American Indian or Alaska Native, White, Native Hawaiian or Other Pacific Islander, Black or African American	Relation	Date of Birth	Male/ Female	Medications	Allergies (food/ medication)
Courageous Camper's Name: _____		Camper				☐ None ☐ _____ _____
Parent/Guardian's Name: _____						☐ None ☐ _____ _____
Parent/Guardian's Name: _____						☐ None ☐ _____ _____
Family Member's Name: _____						☐ None ☐ _____ _____
Family Member's Name: _____						☐ None ☐ _____ _____
Family Member's Name: _____						☐ None ☐ _____ _____
Family Member's Name: _____						☐ None ☐ _____ _____
Family Member's Name: _____						☐ None ☐ _____ _____

Please provide a copy of the insurance card (front and back) for each person with medical coverage.

****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

Elizabeth Turner Campbell, Founder

Today's Date: _____

Courageous Camper's Name: _____

Date of Birth: ____/____/____ **Age:** _____ **Male/Female** **Social Security #:** _____
(required for Summer Camp)

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

Primary diagnosis: _____

Secondary Conditions (if applicable): _____

CHECK ALL DIAGNOSES THAT APPLY:

__ **BLOOD DISORDERS** Hemophilia A___ or B___, Von Willebrand___, ITP___ or Other _____
Does this child self-infuse? Yes___ With Assistance___ No___ Name of factor used: _____
Explain: _____

__ **CANCER** Camper receiving active cancer treatment? ____ In remission? ____ How long? _____
Explain: _____

__ **DIABETES** Oral___ Injection___ Pump___ Name of Insulin_____ Independent___ Needs Assist___
Explain: _____

__ **HEART** Pacemaker___ Transplant___ Oxygen___ Pulmonary Hypertension___ Decreased Ventricular Function_____
Explain: _____

__ **J.A./LUPUS** Treatments Used: _____
Explain: _____

__ **PHYSICAL DISABILITY** Quadriplegia___ Paraplegia___ Shunt___ Rods___ Vesicostomy___ Cecostomy___
MACE___ Bowel/Bladder Incontinence___ Other___
Explain: _____

__ **RESPIRATORY/ASTHMA/ALLERGIES** Asthma Action Plan___ Trach___ CPT___ Suctioning___ Oxygen___ Rate___
Explain: _____

__ **SEIZURE DISORDER** Partial___ Generalized___ Convulsive___ Non-Convulsive___ How often?___
Symptoms prior to seizure: _____ Symptoms after seizure: _____
Special situations that induce a seizure: _____
Explain: _____

__ **SICKLE CELL** History of Acute Chest Syndrome or Moyamoya?_____
Explain: _____

__ **OTHER:** _____

☐ **No Allergies**
☐ **Allergies:**
- ☐ Food/Environmental Allergies: _____
- ☐ Medication Allergies: _____
- ☐ Anaphylaxis reaction to: _____

☐ **Dietary Restrictions**: _____

REQUIRED IMMUNIZATION INFORMATION:

☐ I attest that my camper's immunizations required for school are up to date:

Date of last tetanus booster: _____ **Important!**

------OR------

☐ Exempt from immunizations for religious or medical reasons.

(CCK Statement of Exemption form must be completed).

SPECIALIST PHYSICIAN: _____ Office Number: (___)_____

Specialty: _____ City/State: _____

INSURANCE. The camper has the following (check at least one box):

(NOTE: The Center for Courageous Kids does not bill insurance. Information is gathered for emergency use only.)

☐ No medical insurance
☐ Medical Card – State Program for the state of _____ *(attach copy of card, front & back)*
☐ Passport Medical Card (KY) *(attach copy of card, front & back)*
☐ Private Medical Insurance - Specify Company:_____ *(attach copy of card, front & back)*

CHECK ALL THAT APPLY:

☐Pull Ups/Diapers/Briefs ☐ Night Only ☐Has started menstrual cycle (female)

☐ **SERVICE DOG** – Service(s) the dog provides for the camper: _____ .
(Submit proof of up-to-date service dog Rabies vaccination prior to camper arrival).

ADAPTIVE DEVICES:

☐Wheelchair ☐ Ostomy ☐ Glasses/Contacts
☐Walker/Crutches ☐G-Tube/J-Tube ☐ Hearing Aid:
☐Braces ☐ Oxygen ☐ Other: _____
☐Artificial Limb ☐BiPap

ACTIVITY:

☐ No Restrictions
☐ No Vigorous Physical Activities
☐ Ambulatory
☐ Non-Ambulatory

Does this child have a central venous catheter?: ☐ Yes ☐ NO Type (i.e. broviac, portacath) _____

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

1. _____ Date: _____
2. _____ Date: _____

Does your camper exhibit any atypical behavior when angry, frustrated, or upset? _____
_____

Special bedtime needs:_____

Describe any current stressful family situations: _____
_____

Can your camper (required for Summer Camp): Sleep in a room with other children? ☐ Yes ☐ No
Follow a structured schedule? ☐ Yes ☐ No
Take/follow directions? ☐ Yes ☐ No

Please provide any information that would be beneficial for us to know to provide the best possible experience:
_____
_____

FUNCTIONALITY RATING SCALE (FRS) Scoring Instructions: Please indicate the level of instruction or ability for the child. Comments section is to be used for further details or explanations.

Category	Item	Instructions	Comments
Self Function	Communication Ability	3 = Normal 2 = slightly delayed 1 = markedly delayed 0 = incomprehensible/none	
	Body Movement	3 = normal movement 2 = limited movement 1 = severely limited movement 0 = no movement	
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	3 = completely independent 2 = independent in special environment 1 = moderately dependent 0 = totally dependent	
Social Adaptability	Interaction with others	3 = fully capable 2 = situational limitations 1 = extremely limited 0 = unable to engage with others	
Medical Care	Daily Medications	3 = None 2 = 1-3 Medications 1 = 4-6 Medications 0 = > 6 Medications	
Total FRS Score: _____			

	1-10	11-17	18-24
Counselor:Camper Ratio	1:1	1:2	1:4
HCP:Camper Ratio	1:10	1:20	1:30

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.				

Child must bring all medications in the original container.

Physician's Statement:

(This form is valid for one year from the date of physician's signature.)

I have reviewed the records and acknowledge that the camper, _____, is physically able to attend camp.
(*camper's name*)

- **Date of last exam (*must be within 12 months of desired camp session*):** _____
- **Is Diagnosis provided on page 4 current and accurate? ☐Yes ☐No**
- **If NO, what is the actual diagnosis?** _____

Physician/Nurse Practitioner/PA's Signature: _____Date: ___/___/___

Physician/Nurse Practitioner/PA's Name (PRINT): _____

Address: _____ City: _____

State: ____ Zip Code: _____ Office Phone: (___) _____ Fax: (___) _____

Emergency Contact Number: (____)_____

***REMEMBER* to include the following documents when you send your application to us:**

- ☐ Courageous Camper Application Form – Step 1 (completed on-line or in writing)
- ☐ Courageous Camper Medical Form (with physician's signature) for each Courageous Camper
- ☐ Parental Waiver and Consent Form (completed and signed)
- ☐ Copy of insurance/medical card (front and back) for Courageous Camper
- ☐ Date of last Tetanus Booster (or copy of immunization record)

Family Retreat/Summer Camp
Parental Waiver and Consent Form

Elizabeth Turner Campbell, Founder

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.

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.

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

Service Dogs will be allowed on the premises of The Center. Family pets prohibited.

CHECK ONE … ☐ I do plan **<OR>** ☐ I do not 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.

CHECK ONE … ☐ I accept **<OR>** ☐ I decline medical care for my child and/or family.

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, staff and affiliates to utilize my appearance, performance or voice in any and all manner and media throughout the world for the purpose of promotion, reporting or publication. 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.

CHECK ONE … ☐ I accept **<OR>** ☐ I decline photography release for my child and/or family.

Please contact the Admissions Office 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 all information provided in the application and the medical form is accurate and complete and that I have the legal authority to provide consent on behalf of myself/my child(ren).

(Parental Waiver and Consent Form continued on next page)

Family Retreat/Summer Camp Parental Waiver and Consent Form Page 2

Please list all dependent children (age birth to 17) that will be attending camp.

Camper's Name: _____ (child with diagnosis)

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

All attending Parent(s)/Guardian(s) must sign. Signature represents legal authority for child listed above.

Parent/Guardian (1) Print Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian (2) Print Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Please list any other adult (18 and older) attending camp (i.e. grandparents).

Adult Family Member (1) Print Name: _____

Adult Family Member (1) Signature: _____ **Date:** _____

Please list any other adult (18 and older) attending camp (i.e. grandparents).

Adult Family Member (1) Print Name: _____

Adult Family Member (1) Signature: _____ **Date:** _____

THIS CONSENT FORM IS VALID FOR ONE YEAR FROM DATE OF SIGNATURE.