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 (5-17 yrs) 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: _____ Mark one ethnic identity (optional): _____________
☐ Hispanic or Latino ☐ Asian
☐ Not Hispanic or Latino ☐ American Indian or Alaska Native
☐ African or Black American

Mark one or more racial identities (optional):
☐ Hispanic or Latino
☐ 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________________________________________ State Zip Country ____________
City________________________ County ______________________
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 ☐ Courageous Kids Staff
☐ Media ☐ Website (specify): ____________________________________________
☐ School ☐ 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

Please list every family member attending camp.

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

<table>
<thead>
<tr>
<th>Name</th>
<th>RACE: (optional) Asian, American Indian or Alaska Native, White, Native Hawaiian or Other Pacific Islander, Black or African American</th>
<th>Relation</th>
<th>Date of Birth</th>
<th>Male/Female</th>
<th>Medications</th>
<th>Allergies (food/medication)</th>
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<tbody>
<tr>
<td>Courageous Camper's Name:</td>
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<td>Camper</td>
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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___  Vescicostomy___  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: ____________________
   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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Item</th>
<th>Instructions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Function</td>
<td>Communication Ability</td>
<td>3 = Normal 2 = slightly delayed 1 = markedly delayed 0 = incomprehensible/none</td>
<td></td>
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<tr>
<td></td>
<td>Body Movement</td>
<td>3 = normal movement 2 = limited movement 1 = severely limited movement 0 = no movement</td>
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<tr>
<td>Self Care Activities</td>
<td>Feeding Assistance</td>
<td>3 = independent 2 = minimal 1 = partial 0 = complete assistance</td>
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<td></td>
<td>Toileting Assistance</td>
<td>3 = independent 2 = minimal 1 = partial 0 = complete assistance</td>
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<td></td>
<td>Grooming/Showering Assistance</td>
<td>3 = independent 2 = minimal 1 = partial 0 = complete assistance</td>
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<tr>
<td>Dependence on Others</td>
<td>Level of Functioning</td>
<td>3 = completely independent 2 = independent in special environment 1 = moderately dependent 0 = totally dependent</td>
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<tr>
<td>Social Adaptability</td>
<td>Interaction with others</td>
<td>3 = fully capable 2 = situational limitations 1 = extremely limited 0 = unable to engage with others</td>
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<tr>
<td>Medical Care</td>
<td>Daily Medications</td>
<td>3 = None 2 = 1-3 Medications 1 = 4-6 Medications 0 = &gt; 6 Medications</td>
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**Total FRS Score: ________________**

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<tr>
<th>Counselor:Camper Ratio</th>
<th>1:1</th>
<th>1:2</th>
<th>1:4</th>
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<tbody>
<tr>
<td>HCP:Camper Ratio</td>
<td>1:10</td>
<td>1:20</td>
<td>1:30</td>
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</table>
Please list all medications, including over the counter (OTC).

### Medication Record

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Times medication is given</th>
<th>How medication is given</th>
<th>Purpose of Medication</th>
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</table>

⇒ **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, __________________________ (camper’s name) is physically able to attend camp.

- **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)
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)
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: ____________________________________________

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.

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual’s income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish).