

Camp Dream Catcher  
Epilepsy Foundation of Greater Cincinnati  
895 Central Avenue, Suite 550  
Cincinnati, OH 45202

|   |
|---|
| <b>PARTICIPATION ENROLLMENT FORM</b><br>DATE: _____ |
|---|

**Participant:**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Parent or Guardian:**

Mother:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Father:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Guardian:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Applicant Information:**

A. Disabilities: (be specific) \_\_\_\_\_

B. Specific assistance needed: (ambulation, medication, etc.) \_\_\_\_\_

C. Please check any of the following that apply to the participant:

|                      | <u>Yes</u> | <u>No</u> |                  |
|----------------------|------------|-----------|------------------|
| Uses Wheelchair      | _____      | _____     |                  |
| Uses Walker          | _____      | _____     |                  |
| Uses Crutches        | _____      | _____     |                  |
| Wears Helmet         | _____      | _____     |                  |
| Experiences Seizures | _____      | _____     |                  |
| Frequency: _____     |            |           |                  |
| Type(s): _____       |            |           |                  |
| Has Shunt            | _____      | _____     |                  |
| Has VNS              | _____      | _____     |                  |
| Has Catheter         | _____      | _____     |                  |
| Prescribed Diastat   | _____      | _____     | Last Used: _____ |
| Has Special Diet     | _____      | _____     | Specify: _____   |
| Takes Medication     | _____      | _____     |                  |
| Has Allergies        | _____      | _____     | Type: _____      |

D. Special Interests: \_\_\_\_\_

E. Special Precautions: \_\_\_\_\_

F. Past Programs Attended: \_\_\_\_\_

G. Our curriculum includes swimming and other water activities supervised by trained pool staff.

Is applicant permitted to swim at program? Yes \_\_\_ No \_\_\_

Applicant is currently a: Swimmer \_\_\_ Non-swimmer \_\_\_

H. Other comments or concerns: \_\_\_\_\_

COMMUNICATION SKILLS: Non-verbal: \_\_\_\_\_ Sign Language: \_\_\_\_\_ Facilitated: \_\_\_\_\_

**\*\*ALL MASTER INFORMATION AND RELEASE STATEMENTS ARE ACCEPTED FOR A 2 YEAR PERIOD. IT IS YOUR RESPONSIBILITY TO NOTIFY THE EPILEPSY FOUNDATION/CAMP DREAM CATCHER OF ANY CHANGES.**

**Contact Information:**

Primary Emergency Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Phone #2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Other Emergency Contacts:

(1) Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Phone #2: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(2) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone  
#2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Worker (If Applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**PLEASE READ THE FOLLOWING CAREFULLY AND THEN SIGN EITHER A OR B:**

**A.** I grant consent to transport applicant to a designated source(s) of emergency medical or dental care, if necessary.

\_\_\_\_\_  
Signature: Parent or Legal Guardian Date

**B.** I do **not** grant consent to transport applicant for emergency treatment but instruct the Epilepsy Foundation to do the following in the event of a medical emergency:

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

\_\_\_\_\_  
Signature: Parent or Legal Guardian Date

**EMERGENCY MEDICAL RELEASE**

In the event the undersigned cannot be reached in an EMERGENCY SITUATION, the undersigned hereby gives permission to the physician selected by the Camp Director or his/her designee to hospitalize and/or to secure proper treatment, including, but not limited to, injection, anesthesia or surgery for the applicant named below. The undersigned accordingly releases jointly and separately the Epilepsy Foundation of Greater Cincinnati; Camp Dream Catcher; any agency with which any of those organizations may be affiliated; and the officers, employees, trustees, volunteers and members of each of them of any and all damages; liabilities; causes of action and/or obligation of any nature whatsoever past, present or future; known or unknown arising out of and/or relating in any way to the above medical treatment or decisions relating to the same.

NOTE: Upon admission for emergency treatment, health insurance carried by the undersigned, as indicated below, will cover costs of such treatment.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent or Legal Guardian

Medical Insurance Company: \_\_\_\_\_

\_\_\_\_\_  
Policy number

\_\_\_\_\_  
Plan number

\_\_\_\_\_ I do not carry Medical Insurance.

**MEDICATION RELEASE FORM**

I agree to allow Epilepsy Foundation staff and Camp Dream Catcher staff to administer the medications listed below at the times listed below to my child who is not able to self-administer his/her medications or who becomes unable to self-administer his/her medications under some extraordinary circumstance. In the event that my child is in need of over-the-counter medications, I authorize the Epilepsy Foundation staff and Camp Dream Catcher staff to administer over-the-counter medications when appropriate with any exceptions listed below.

| Medication: | Dosage: | Frequency: |
|-------------|---------|------------|
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |
|             |         |            |

My child is able to self-administer his/her own medications under normal circumstances:

Yes \_\_\_\_\_ No \_\_\_\_\_

Over-the-counter medications my child may **not** receive:

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

\_\_\_\_\_  
Signature: Parent or Legal Guardian

\_\_\_\_\_  
Date

**Release Form**

In consideration of the acceptance of: \_\_\_\_\_  
Applicant's Name

for any of the programs provided by the Epilepsy Foundation of Greater Cincinnati, the undersigned hereby assumes complete and sole responsibility for any injury to person or any damage to property sustained or incurred by the applicant arising out of and/or relating in any way to any activities, programs, or transportation to and from any Epilepsy Foundation of Greater Cincinnati Camp Dream Catcher, Epilepsy Foundation of Greater Cincinnati Respite Program, Epilepsy Foundation of Greater Cincinnati Special Programs/Field Trips, including the transportation to and from and participation in any of the above contemplated sessions, programs or periods. The undersigned agrees to allow the applicant to participate in: all activities at Camp Dream Catcher; all activities included in the Respite Program; all activities included in any Special Program/Field Trip; and to participate in travel that is involved as a part of any of these programs, sessions or periods. The undersigned accordingly releases jointly and separately the Epilepsy Foundation of Greater Cincinnati, Camp Dream Catcher, the Respite Program and any agency with which any of these organizations may be affiliated; including the officers, employees, trustees, volunteers and members of each organization; of any and all damages, liabilities, causes of action and/or obligations of any nature whatsoever past, present or future, known or unknown arising out of and/or relating in any way to the above programs, activities, sessions and the transportation to and from any Epilepsy Foundation of Greater Cincinnati Camp Dream Catcher, Respite Program, or Special Program/Field Trip. The Epilepsy Foundation will reserve the right to exclude any client that is known to pose a serious risk of harm. Program Administration will consider behavior, health, safety and potential risk before recommending exclusion.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent of Legal Guardian

The signature of the parent or legal guardian above does hereby represent that he/she is, in fact, acting in such capacity and agrees to save and hold harmless and indemnify each and all of the parties referred to above from all liabilities, cost and/or claim for damage whatsoever which may be imposed upon said parties because of any defect or lack of such capacity to so act and release said parties on behalf of the and the parents or legal guardian.

