

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

PARTICIPATION ENROLLMENT FORM

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: _____

Cell phone: _____ e-mail _____

Employer's Name: _____

Address: _____

Phone: _____ e-mail: _____

Father:

Last Name: _____ First: _____ M.I.: _____

Address: _____ Phone: _____

City/State/Zip: _____

Cell phone: _____ e-mail _____

Employer's Name: _____

Address: _____

Phone: _____ e-mail: _____

Guardian:

Last Name: _____ First: _____ M.I.: _____

Address: _____

City/State/Zip: _____ Phone: _____

Cell phone: _____ e-mail _____

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.**

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.

