



**2019 CAMP NOVA @ YMCA CAMPER
APPLICATION ADDENDUM**

Epilepsy Services of New Jersey

"AFFILIATED WITH THE FAMILY RESOURCE NETWORK "

**35 Beaverson Blvd. building 11
Brick, NJ 08723**

Phone #: (800) 336-5843

Camper's Name: _____

Male___ Female___ Last First Middle
Age___ Birthdate _____ Weight _____ Height _____

How much assistance does your camper need from a counselor: 2:1 OR 3:1

Parent/Guardian Email: _____ Camper Email: _____

MEDICAL SUMMARY

Camper's Primary Diagnosis: _____

Secondary Diagnosis: _____

Which disability(s) apply to your camper? (Please circle all that may apply)

- | | | | |
|-------------------|----------------|-----------------------|-------------------|
| Epilepsy | Non-Ambulatory | IDD | Medically Fragile |
| Hearing Impaired | Cerebral Palsy | Visually Impaired | Alpha Order |
| Autism | Orthopedic | Neurological Impaired | Other _____ |
| Attention Deficit | Hyperactive | Emotional Disturbance | |

A. Hearing (Circle One)

- Normal
- Mild/Moderate Loss
- Severe/Total Loss
- Hearing Aid? Yes No

B. Vision (Circle One)

- Normal
- Mild/Moderate
- Severely Affected
- Glasses/Contacts? Yes No

C. Speech (Circle One)

- Normal
- Mildly/Slightly Affected
- Non-Verbal

Camper's Ability to Communicate: (Circle all that apply):

- Normal
- Uses only a few words
- Uses sign language
- Gestures
- Communication Board
- Other: (Please Specify) _____

D. Mobility (Circle One)

- Walks Normally
- Walks with Assistance
- Wheelchair for Distances
- Able to climb stairs? Yes No
- Walking Ability Affected, But Independent
- Wheelchair Exclusively: Manual Electric
- Walks with Assistance Device (Please Specify) _____

E. Behavior

Does the applicant have any behavior difficulties? Yes _____ No _____ If yes, please explain in your own words details of the unfavorable/ inappropriate behavior (i.e. kicks, punches, bites, etc.).

Does your child currently have a Behavior Plan? Yes No

Name & Phone # of Behaviorist:

****DOCUMENTATION/ BEHAVIOR PLAN FROM BEHAVIOR SPECIALIST IS REQUIRED.**

How does the camper generally handle transitions? If the camper has difficulty, please describe any resistant or aggressive behavior exhibited by the camper and how to handle it:

Describe in detail, specific methods or techniques which you or the camper's teachers use that have been successful in dealing with any unfavorable behavior exhibited by the camper:

Consent #1

I, _____, hereby give permission to the Camp Director, to contact the applicants Behavioral Specialist for assistance with behavior modification, if needed.

Parent / Legal Guardian Signature _____ Date _____

SEIZURE SUMMARY (if no seizures, put n/a)

Does your child have a seizure disorder: _____ Yes or _____ No

Types of Seizures (if applicable): _____

Note: If yes, additional information will be asked at our home visit.

I wish to be notified for **EVERY** seizure _____ Yes _____ No

I wish only to be **NOTIFIED** for the following seizure activity: _____

ALLERGIES: _____

Adaptive Devices and Physical Aids (Circle each one the camper has):

- | | | | |
|----------------|-------------------|---------------------|-----------------------------|
| Eye Glasses | Elastic Stockings | Retainer | Adaptive Feeding Equipment |
| Contact Lenses | Splints | Feeder Seat | Communication Board |
| Braces | Diapers/Attends | Crutches/Walker | Special Bathing Equipment |
| Helmet | Hearing Aid | Positioning Commode | Corrective/Orthopedic Shoes |

PERSONAL HABITS/CARE (Please circle any of the descriptions which apply to your camper)

Appetite:

Above Normal
Normal
Below Normal
Picky

Eating:

Independent
Partial Assistance – Cutting
Can feed self finger foods
Require complete assistance

Adaptive Devices for Eating: (Must be sent with camper): _____

Special Food Preparation: (circle)

None
Chopped/Cut
Ketogenic Diet *** (All food MUST be prepared at home, prepackaged and brought to camp.)

Special Diet
Pureed

Swallowing Difficulties: (circle)

None
Liquids
Solids
Uses straw

Adaptive Devices/Braces/Equipment Used (Please list):

Bathroom Needs (Bladder Control): (circle)

Normal
Has Accidents
Incontinent
Wets Bed

Bathroom Needs (Bowel Control): (circle)

Normal
Has Accidents
Incontinent

Bathroom Assistance Needed:

None Partial Assistance Total Assistance

Has this camper menstruated? Yes No

If yes, is menstrual history normal? _____ If no, has she been told about it? Yes No

If yes, POOL Diapers are required the week of camp – NO EXCEPTIONS

Aids Used: (circle)

Diapers (___Night Only ___All the time)
Toilet Chair Suppositories Bed Pan Laxatives Urinal Enemas (Please pack if needed)

Describe the camper's swimming ability.

Should your child wear a life preserver in the swimming pool? Yes No

Please Note: If your child requires one to one in the swimming pool, a life preserver will be required. A note from the doctor is required if your child does NOT have to wear a life preserver.

ACTIVITY RESTRICTIONS

Include any specific concerns, restrictions you may have regarding any activities- be specific. *The final activity schedule will be provided closer to camp.*

Please list restrictions on activities: _____

Camp NOVA does not assume the risks, including, but not limited to, those outlined in the above section.

Signature of Parent / Legal Guardian _____ **Date** _____

RELEASES

CLAIMS AND CONSENT

The undersigned hereby releases The Epilepsy Services of New Jersey (ESNJ) and its volunteers, consultants and employees and the Outdoor Center and its employees, from any and all losses, liabilities, claims, expenses, damages to property, death or personal injury including, without limitation, attorney's fees which may be incurred, or asserted against, the undersigned or the children undersigned in connection with the transportation of the undersigned and/or the children of the undersigned to and from the ESNJ's Camp NOVA.

Signature _____ Date _____

The undersigned hereby authorizes employees, camp counselors and volunteers of ESNJ, to review the application and personal/medical file of _____ in connection with the ESNJ's Camp NOVA.

Signature _____ Date _____

The undersigned hereby gives permission to the medical personnel selected by Camp NOVA & the YMCA, to provide necessary treatment/emergency medical care including x-rays, routine tests, and treatment; to release any records for insurance purposes: and to provide/arrange for necessary transportation. In the event of an emergency, and I cannot be reached, I hereby give permission to the selected physician to secure and administer treatment, including hospitalization for my child _____.

Signature _____ Date _____

VIDEO AND AUDIO RECORDING

I, _____, do hereby consent to the video/audio taping of my child, _____, by ESNJ at any time during the attendance at the ESNJ's Camp NOVA program from _____.

I understand that the video/audio tape may be made available only for educational, informational, fundraising and/or publicity purposes and I consent to such use on behalf of myself and my child.

I hereby release ESNJ from any and all claims arising out of such photographic, reproductive, publishing or exhibiting as is authorized by ESNJ.

Signature (Parent/Guardian) _____ Date _____

PHOTOGRAPHY

I, _____, do hereby consent to the filming, photographing and/or publication of an existing photograph of my child, _____, by ESNJ at any time during attendance at ESNJ's Camp NOVA to be held _____.

I understand that photographs taken may be made available only for educational, informational, and fundraising and/or publicity purposes and I consent to such use on behalf of myself and my child. I also consent to the use of my child's name for said purposes.

I hereby release ESNJ from any and all claims arising out of such photographing, reproducing, publishing or exhibiting as is authorized by ESNJ.

Signature (Parent/Guardian) _____ Date _____

GUIDELINES FOR CAMP NOVA

PLEASE COMPLETE **ALL**

EMERGENCY POLICY

We have updated our policies in regards to Emergencies. If a Local, State or National Emergency is declared Camp NOVA will do what is instructed by the authorities. However, if we are asked to evacuate, we ask that all parents / guardians pick up their child once contacted by the Camp within two hours or within a reasonable time agreed upon by the Director and the family.

Please verify with the Medical Staff all your emergency numbers. You must provide at least one number for someone who will be able to reach you or has your permission to pick up your child in the event of an emergency.

Please sign below that you have read and verified your information with the Medical Staff and provided the necessary information.

PARENT / GUARDIAN SIGNATURE

DATE

In the event there is an emergency at Camp NOVA during the week of _____ it is imperative that we have emergency contact information on file. Please list the information below and return to us prior to camp. (PLEASE WRITE OR PRINT LEGIBLY).

Camper's Name: _____

Parent / Guardian: _____ Home #: _____

Cell Phone #'s: _____ Work Phone #'s: _____

Emergency Contact Person: _____

Relationship: _____ Phone Number(s): _____

INSURANCE INFORMATION (ATTACH COPY OF MEDICAL CARD)

Is applicant covered by family medical/hospital insurance? Yes No Group # _____

If so, indicate Carrier Name & Address _____

Named of insured _____ Relationship to applicant _____

Social security number of policy holder or insurance ID number _____

Authorization to Treat Medical Emergencies

The undersigned hereby authorizes the employees and volunteers of Camp NOVA and the Epilepsy Services of New Jersey, to review the application and personal medical file of _____.

This is in connection with Camp NOVA in conjunction with the Epilepsy Services of New Jersey, to be held at the YMCA Facility.

The undersigned also authorizes any doctor, hospital or other provider of medical services to release to Camp NOVA and the Epilepsy Services of New Jersey, its employees and volunteers any and all medical information concerning my child, including but not limited to medical records, x-rays and/or hospital records.

I further authorize Camp NOVA, the Epilepsy Services of New Jersey, its employees and volunteers to authorize any medical treatment to be rendered either by a Nurse, Emergency crew and/or hospital which may be deemed for my child, _____ during my child's week at Camp NOVA.

Parent/Guardian Signature: _____ Date: _____