Children's HOSPITAL • ST. LOUIS

One Children's Place
St. Louis, Missouri 63110-1077
www.stlouischildrens.org

ACCREDITED

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

SUMMER CAMP INDEPENDENCE 2019
Information Sheet and Checklist

Camp Independence Location:
Webster Groves Recreation Center
33 E. Glendale
Webster Groves, MO 63119
(314) 963-5600

Important Phone Numbers/Emails
Mary Eckhard 314-454-2642/mary.eckhard@bjc.org
Jennifer Miros 314-454-2604/jennifer.miros@bjc.org
Fax Number: 314-454-6035

Complete all paperwork as soon as possible to ensure participant's spot in camp.

Items to be completed prior to Camp Independence start date and returned by email, mail or fax:

1. Camper Application (Please make certain that ALL items are completed – Insurance information needs to be filled out completely.)
2. Camper Medical History.
3. Authorization/Waiver Form.
4. If Applicable: Seizure Action Plan, Food Allergy & Anaphylaxis Emergency Care Plan, Medication Administration Form.
5. Prescription for Physical Therapy: All campers need a prescription/medical clearance from their physician to participate in Camp Independence. If the camper is not a patient of the Cerebral Palsy Center, the camper must obtain this script from their private physician. (See prescription example if physician needs a template.)
6. Authorization for Release of Media Information-consent for pictures/video to be taken at Camp Independence.

Mail to: Mary Eckhard
CP Sports-4E 2
St. Louis Children's Hospital
St. Louis, MO 63110

OR fax to:

ATTN: Mary Eckhard
Fax Number: 314-454-6035
***Please call Mary at 314-454-2642 to make sure that we received your fax**

The cost of Camp Independence is $780/week or $156/day.

- Billing for camp (camp is really an "intensive physical therapy outpatient group treatment" when speaking to insurance companies) will be done through St. Louis Children's Hospital Patient Accounts and the cost of this therapy will first be billed through your insurance company.
- Each day of camp attendance is billed as a Physical Therapy Outpatient Group Therapy Charge and counts as 1 Physical Therapy Visit per day. Please make sure that you have not maxed out on your PT visits and that you have visits remaining to cover the days at camp.
- Claims will be submitted through your insurance company, but this does not guarantee payment. If your insurance company denies the claim, you will be responsible for the bill.
- Financial assistance/Financial counselors are available to assist with payment plans.
- For questions, call 314-454-2642.

Cancellation Policy: Due to increasing registration demands and waiting lists for Camp Independence, the following Cancellation Policy is in effect. In the event a camper does not show up at Camp Independence for a scheduled day or week, or if there is a late cancellation (less than 24 hours prior to the camp day) that is deemed frivolous (decided not to go, too early/late of start time, forgot about Camp, forgot to cancel earlier, can't afford, found something else to do), that camper will not be permitted to attend the next scheduled Camp Independence.

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American Camp Association ACCREDITED

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

SUMMER CAMP INDEPENDENCE 2019
Designed exclusively for young people with Cerebral Palsy
Sponsored by
THE CAROL AND PAUL HATFIELD CEREBRAL PALSY SPORTS AND REHABILITATION CENTER

Complete this application as soon as possible to ensure participant's spot in camp.

Camper Application

Name:_____ Date of Birth:_____ Male/Female:_____

Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone #:_____ Email Address:_____

Mom's Name:_____ Dad's Name:_____

Mom's Work/Cell Phone#:_____ Dad's Work/Cell Phone #:_____

Emergency Contact (Other than Parent) Name/Relationship:_____

Emergency Daytime Telephone #:_____

Check which of the following session(s) in which you'd like to participate (**up to 3 weeks**):

☐ June 10-14, 2019 ☐ July 8-12, 2019

☐ June 17-21, 2019 ☐ July 15-19, 2019

☐ June 24-28, 2019 ☐ July 22-26, 2019

Please circle the correct size: T-shirt – Youth S M L

T-shirt - Adult S M L XL

Additional T-shirts may be ordered if desired for $10 per shirt. _____Size of Shirt(s) Needed

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Can the camper walk independently? Yes No

If the camper uses an assistive device to walk, please describe the assistive device (walker, canes, etc.) and how often they use it. 25% 50% 75% 100% of walking time.

_____

If the camper uses a wheelchair, how is the wheelchair propelled?

Camper pushes Camper drives power wheelchair Camper is dependent on someone else to push/drive

Can the camper transfer in and out of wheelchair independently?

Yes OR with 25% 50% 75% 100% assistance.

What does camper use for long distances? Walk wheelchair

Can the camper sit on a bench independently? Yes or With 25% 50% 75% 100% assistance

Can the camper hold a ball? Yes No_ Throw a ball? Yes No Kick a ball? Yes No

Can the camper swim independently? Yes No With 25% 50% 75% 100% assistance?

Equipment/Floatation required: noodle/belt/life jacket/ other_____

PLEASE BRING THIS EQUIPMENT TO CAMP

How does the camper communicate? Talks, Sign Language, AAC Device, other:_____

Can camper toilet independently? Yes No If no, what assistance is needed? (Diapers, needs help transferring, needs help cleaning, etc.) _____

Does the camper have any difficulty with eating? Yes No If yes, please describe (Food must be cut or liquids must be taken through straw, etc.) and if requires g-tube feeding. _____

_____

Does the camper have any medical conditions other than cerebral palsy (asthma, breathing difficulties, heart trouble, etc.)? Yes No If yes, please list.

_____

Does the camper have a seizure disorder? Yes No If yes, please list frequency of seizures and treatment plan._____

Does the camper have any allergies? Yes No If yes, list allergies._____

_____

Is the camper currently taking any medications? Yes No If yes, please list. _____

_____

Does the camper have any behavior or attention problems that could interfere with his or her ability to participate? Yes No If yes, describe _____

_____

What type of posititive reinforcement is most effective with your child? Praise, reward, etc?_____

_____

What type of discipline is most effective with your child? Time out, gentle voice, stern voice, etc?

_____

May we contact the camper's physician and request necessary records regarding his or her medical condition? Yes No If yes, please list physician(s) and phone numbers. _____

_____

What is the camper's reason for coming to camp? _____

_____

What are the camper's goals for camp? _____

_____

Any additonal information the staff should know about your child prior to attending 2019 Summer Camp Independence?_____

_____

_____

Please complete the following insurance information: **If we do not receive this information, a prior pre-auth cannot be obtained.**

Insurance Carrier _____

ID Number: _____ Group No.: _____

Subscriber's Name: _____

Pre-Authorization Phone Number (usually on back of the card)_____

Provider Services Phone Number (usually on back of card)_____

Media Release Form

MEDIA/PHOTO WAIVER: I hereby authorize and give my full consent to the Carol and Paul Hatfield Cerebral Palsy Sports and Rehabilitation Center to copyright and/or publish any and all photographs, videotapes and/or film in which the camper appears while attending Camp Independence. I further agree that the Cerebral Palsy Center may transfer, use or cause to be used, these photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, and television programs without limitations or reservations.

Parent/Guardian Signature_____ Date_____

Print name_____

Please complete the information below, which will be turned into a notecard to better help our volunteers assist and know some topics to talk about with your child.

Camper's Name/Nick Name:_____

Things He/She Likes (foods, colors, TV shows, games):

_____

Favorite Sport:_____

Preferred Positions (i.e. sitting on floor, in chair, etc):

_____

Positions to Avoid: _____

Communication Tips: _____

Other help information:

_____

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

ACCREDITED

Children's HOSPITAL • ST. LOUIS BJC HealthCare

CAMP INDEPENDENCE

Camper Medical History

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Medications (daily or on an as needed basis): _____

If taking medication at camp, complete Medication Administration Form.

Seizures: Yes No If yes, complete Seizure Action Plan Form.

Allergies: Yes No If yes and Epipen required, complete Food Allergy & Anaphylaxis Emergency Care Plan Form.

Dietary Restrictions _____

Please indicate current or past special needs in the following system areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Speech			
Cardiac			
Pulmonary			
Neurologic			
Orthopedic			
Cognitive/ Learning Difficulties			
Emotional/Psychological			
Pain			
Other			

Tetanus Shot: Month: _____ Year _____

By signing the form below, I attest that ALL immunizations required by school are up to date, including the month/year of the last tetanus shot.

Parent Signature: _____

Date: _____

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

ACCREDITED

Children's HOSPITAL • ST. LOUIS
BJC HealthCare

AUTHORIZATION/WAIVER FORM

Name of Camper _____

DESIGNATION OF AUTHORIZED INDIVIDUALS:
We request that you designate those individuals authorized to pick-up your child from Camp Independence. **Please include yourself.** Photo ID must be presented at the time of pick-up.

1. _____ Contact #: _____
   Name/Relationship to child
2. _____ Contact #: _____
   Name/Relationship to child
3. _____ Contact #: _____
   Name/Relationship to child

MEDICATION ADMINISTRATION CONSENT:

I (we) consent to the Cerebral Palsy Sports and Rehabilitation Center of St. Louis Children's Hospital staff ("Staff") to administer to my child the medication listed in the camp application and medication administration form as directed by my child's physician. I have provided Staff with the medication to administer in a pharmacy-marked container labeled with my child's name, date, dosage and time of administration. I understand that any medication provided that is not appropriately labeled will not be administered to my child.

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

In case of an accident or illness, I (we) authorize Staff to make necessary arrangements for emergency medical treatment in the event that I (we) can not be contacted timely. I authorize an ambulance to transport my child to the nearest hospital for emergency medical treatment and agree to pay for the medical care and treatment provided. If child has a seizure disorder, fill out seizure action plan form.

CAMPER PARTIPATION RELEASE:

I understand that participation in Camp Independence is voluntary and may benefit my child. In authorizing my child's participation in Camp Independence, I release and hold harmless, for myself and my child, St. Louis Children's Hospital and the Cerebral Palsy Sports and Rehabilitation Center including its representatives and employees (collectively, the "Center") from any and all liability, claims or demands for damages, whether for personal injury or any other type of injury, relating to or arising from my child's participation at Camp Independence.

I have read and understand the above consents, authorizations and release. Based on the above, I authorize and direct my child's participation at Camp Independence.

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

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

Pediatric Neurology Cerebral Palsy Center

St. Louis Children's Hospital
One Children's Place • St. Louis. MO 63110
Office: (314) 454-6120 Fax: (314) 454-2523

Patient Name: Joe Camper
DOB: 7/8/98

Date: June 1, 2019
Phone Number: 543-2100

Rx: Physical Therapy Day Treatment.
Provide strength, balance, flexibility and endurance training.

Diagnosis/ICD-10 Code:
Duration: 5 days
Precautions:

Physician Signature

Print Name