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

WINTER 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 by December 16 to ensure participant's spot in camp.

Items to be completed and returned by 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 CP script sample.)
6. Photograph/Video - If the CP Center has not evaluated your child, please send a current photograph or video of the child's functional status (walking, pushing self in w/c, etc.).

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.

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

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St. Louis, Missouri 63110-1077
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WINTER CAMP INDEPENDENCE 2019
A sports day treatment designed exclusively for young people with Cerebral Palsy

Sponsored by
THE CAROL AND PAUL HATFIELD CEREBRAL PALSY SPORTS AND REHABILITATION CENTER

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 day(s) you'd like to attend: (1 or 2):

☐ December 30, 2019 (Bring warm clothes for ice-skating)

☐ December 31, 2019 (Bring warm clothes for ice-skating)

If you would like a shirt from Summer Camp - please indicate size:

Youth S M L

Adult S M L XL

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? Please Circle:

Camper Pushes Camper Drives Power Chair Camper is Dependent on someone else to push/drive

Can the camper transfer in and out of wheelchair independently? Please Circle:

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

What does camper use for long distances? Walk or wheelchair?

Can the camper sit 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

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, bowel or bladder difficulties, difficulty eating or gaining weight, 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 medications and time schedule.

_____

Does the camper have any behavior or anxiety (i.e. separation) problems that could interfere with his or her ability to participate? What treatments is he or she receiving for this? _____

_____

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?

_____

If your child has a behavior plan for school or home-please send with this application.
May we contact the camper's physician and request necessary records regarding his or her medical condition? 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 Winter Camp Independence?_____

_____

_____

Does the camper attend regular physical therapy sessions? If so, where? Therapist name? _____

_____

PLEASE note that you will need to cancel any PT sessions on dates that the camper is attending Camp Independence due to insurance restrictions*

All campers need a prescription and medical clearance from his/her physician to participate in Camp Independence and to bill insurance. If the camper is not a patient of the Cerebral Palsy Center, the camper must obtain these from his/her private physician. Please return these documents with the completed application.
Return this form, and if we do not know your child, send a current photograph or video of the child's functional status (walking, pushing self in w/c, ect.) to:

Jennifer Miros, MPT
St. Louis Children's Hospital, One Children's Place
Therapy Services – 4E2
St. Louis, MO 63110-1077
or

fax to (314) 454-6035. If you fax this, call (314-454-2642) to make sure our office received it.

Applications are DUE by December 16, 2019.

Campers will undergo pre and post assessments of strength, endurance, balance and self-esteem. Documentation will be completed on the progress of each camper throughout the week.

The cost of Camp Independence $156/day.

- Billing for camp will be done through St. Louis Children's Hospital Patient Accounts and the cost of camp will first be billed through your insurance company.
- 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 is available for those who qualify.
- Financial Counselors are available to assist with payment plans.
- For questions, call 314-454-2642.

Please complete the following insurance information and **attach a copy of your medical insurance card for pre-authorization.**

Insurance Carrier _____

ID Number: _____ Group No.: _____

Subscriber's Name: _____

Cancellation Policy:

Due to increasing registration demands and waiting lists for Camp Independence, the following Cancellation Policy is now being implemented. 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.

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 staff/volunteers assist your child.

Name/Nickname: _____

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

Favorite Color: _____

Favorite Sport(s): _____

Transfer Ability: **Indep/Needs Asst**.-fill in below if not Indep.

Amount of Asst: **Max/Mod/Min/Contact Guard/Stand By Assist**

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

Positions to Avoid (i.e. laying on belly): _____
_____

Communication Tips:_____

Other helpful hints: _____
_____
_____

CAROL AND PAUL HATFIELD CEREBRAL PALSY Sports & Rehabilitation Center

CAMP 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

CAMP 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 the Staff 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**

Children's HOSPITAL • ST. LOUIS

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: 7/8/2009

Date: Dec 1, 2019
Phone Number: 314-543-2100

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

Duration: 2 days
Precautions:

_____
Physician Signature

_____
Print Name