CLOVERNOOK
CENTER FOR THE BLIND & VISUALLY IMPAIRED

CLOVERNOOK CENTER FOR THE BLIND AND VISUALLY IMPAIRED
SUMMER CAMP 2019

APPLICATION

CHECK BOXES THAT APPLY

PRE-SCHOOL CAMP: JUNE 3RD-7TH (AGES 4 TO 6 YEARS)
JR. CAMP: JUNE 10TH- 14TH (AGES 7 TO 12 YEARS)
SR. CAMP: JUNE 17TH- 21ST (AGES 13 TO 25 YEARS)
SPORTS CAMP: JUNE 24TH-28TH (AGES 7 TO 12 YEARS)

DEMOGRAPHIC INFORMATION FOR YOUTH

Name: Last First M.I.
Street: Apt#:
City: State: Zip Code: County of Residence:
Phone, beginning with area code: Home Cell
Male Female Ethnicity Date of Birth:
US Citizen: Yes No
Level of Education: (fall 2018)

PARENT/GUARDIAN INFORMATION (PLEASE PRINT)

Name: Last First M.I.
Street: Apt#:
City: State: Zip Code: County of Residence:
Phone, beginning with area code: work home
cell alternative phone email

PARTICIPANT'S LEGAL STATUS. CHECK ALL THAT APPLY.

Do you have legal Guardianship? Yes No
Minor Own Guardian Conservator Court Appointed Date:
Guardian of Estate Stand by Limited Emergency Interim
Person Power of Attorney Date:
General Medical Springing Financial Durable Other:

PROOF OF GUARDIANSHIP/CONSERVATORSHIP Yes No

***** PLEASE PROVIDE AND ATTACH COURT DOCUMENTATION*****

Does your child receive services from a county Board of Developmental Disabilities?

Yes No

Name of School:

Address: City: State: Zip Code:

School Phone, beginning with area code:

School Fax:

Teacher of Visually Impaired's name (TVI):

Teacher of Visually Impaired's phone, beginning with area code:

Teacher of Visually Impaired's email:

VISUAL IMPAIRMENTS:

Select one: Legally Blind Severely Visually Impaired Does not Apply

Date of last eye exam: Eye Pathology:

Acuity (if Known) O.D. O.S.

Field Restriction Yes No (If yes) explain:

What Low Vision Aids are currently used:

Preferred Media for Written Materials: (check all that apply)

Braille Large Print Regular Print CD Reader

ADDITIONAL DISABILITIES AND MEDICAL INFORMATION (CHECK ALL THAT APPLY)

Audiolingual Neurological Psychiatric Cognitive Orthopedic

Speech/Communication Other:

Significant medical condition: Yes No (If yes,) Explain:

ASSISTIVE DEVICES (CHECK ALL THAT APPLY)

White Cane Guide Dog Wheelchair Support Cane Walker

Crutches Other:

INITIAL SERVICE PLAN

Statement of Need:

Check all that apply:

Activities/Recreational Art Class Braille Instruction Technology

Case Management Job Coaching Job Placement Work Readiness
Orientation & Mobility Other:

OTHER AGENCY INVOLVEMENT (CIRCLE ALL THAT APPLY)

OOD/BSVI OOD/BVR County Board DD Services CABVI
Vision Coalition of Cincinnati Physician:
Social Service Agency:

CAMP JOY OVERNIGHT CAMP – CHECK BOX(ES) THAT APPLY

My child will not attend Camp Joy Overnight Camp
Will attend Camp Joy Overnight Camp June 13 – 14
Will attend Camp Joy Overnight Camp June 20 – 21

I understand that completing and signing this form is a prerequisite for my or my child's participation in Camp Joy's programs.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (dba Camp Joy) and Joy Outdoor Education Center Foundation, Inc., is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

Activities: I am aware that experiential, outdoor pursuits for which I have enrolled such as living history reenactments (Ex. Underground Railroad), hiking, walking on uneven ground, challenge courses, ground initiatives, mountain biking, archery, swimming, and other activities at Camp Joy entail certain risks. Camp Joy has a number of challenge courses that can include poles, ropes, cables, and platforms on which participants move with and without the assistance of staff and other participants. The level of exertion required for the activities will be similar to a day of moderate to strenuous exercise. Activities are explained by staff, and belay or other support systems may be used. Activities vary in height and difficulty.

Risks: I understand and acknowledge that experiential education including high ropes courses and other Camp Joy activities involve risks which could result in injury, tripping, falling, broken bones, burns, death, or damage to my property. I may be in situations in which I depend on others for my physical well-being. The risks described and others are inherent in Camp Joy activities and without them the activities would lose their essential character and value.

Camp Joy recommends consulting with a physician for the following: heart and blood pressure conditions, recent surgeries, and back and neck issues before participating in challenge course activities. Expectant mothers are not permitted to fully participate in challenge course activities. Per manufacturer specifications, participants must not exceed 300lbs for challenge course activities.

Release: I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates (including the Warren County Astronomical Society with respect to our Observatory), representatives, successors, and assigns, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether known or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any Camp Joy program, including, but not limited to any physical injury, psychological injury, or loss of life or personal property that may occur as a result of participating in this program.

Photography: I understand that photography commonly occurs during Camp Joy programs. I consent for myself and/or my child/minor of legal responsibility to be photographed for general Camp Joy use, including program and/or agency printed/internet publicity.

☐ Check this box to decline the photo release.

Authorization for Treatment: I give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant, and for the visiting organization or Camp Joy to secure and administer treatment, including hospitalization, for the participant named below.

Signature: I have read, understand, and accept the terms and conditions stated in this Risk and Release Form. The named participant has permission to engage in program activities, except as noted.

I understand that my signature on this Release form will remain valid for one year of programs at Joy and I acknowledge my obligation to inform Camp Joy in advance of any changes in the child's/participant's health that may affect the child's/participant's ability to participate in activities in any way. I certify that the information my child or I have provided is complete and accurate.

Parent Signature Date

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MEDICAL/EMERGENCY SUMMARY

CONSUMER INFORMATION

Full Name:

Last First M.I.

Insurance Company: Policy Number:

Medicaid Number: Medicare Number:

EMERGENCY CONTACT

Full Name:

Last First M.I.

Phone (Home/Cell): Phone (Home/Cell): -

Relationship:

ALTERNATE EMERGENCY CONTACT

Full Name:

Last First M.I.

Phone (Home/Cell): Phone (Home/Cell):

Relationship:

PREFERRED HOSPITAL

Name:

PRIMARY PHYICIAN

Name:

Phone:

ALTERNATE PHYSICIAN

Name:

Phone:

PREFERRED OPHTHALMOLOGIST

Name:

Phone:

OTHER INFORMATION

Name:

Phone (Home/Cell):

OTHER INFORMATION

Pertinent Past Medical History and/or Psychological History (additional disabilities included):

ALLERGIES:

SPECIAL DIET:

Has your vision changed over the last year? If yes, please describe.

PARENT/GUARDIAN PERMISSION FOR EMERGENCY TREATMENT

I, ,do hereby permit Clovernook Center for the Blind and Visually Impaired to provide emergency treatment and/or first aid for in the event of a medical emergency, and I cannot be contacted. I give permission for to be transported to a hospital or doctor's office for treatment and do hereby authorize such treatments that may be necessary.

Parent/Guardian Signature Date

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ADL & O/M FUNCTION SHEET (PLEASE PRINT)

NAME: **DATE OF BIRTH:**

Check the level of function of each activity of Daily Living listed below. This will help us in determining the need for ADL classes and O&M Instruction.

Function	Independent	Needs Help	Dependent	Does Not Do
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking with cane				
Climbing Stairs				
Eating				
Cooking				
Shopping				
Managing medication				
Using phones				
Housework				
Doing laundry				
Money				
Computer skills				
Reading braille				
Using brailler				
Using transportation				
Patience				
Trust of others				
Tying shoes, buttoning shirts, etc.				

Miscellaneous information:

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ACTIVITY RELEASE AND MEDICAL CARE AUTHORIZATION

I am _____ ("Participant"), in the Visionary Camp Program hosted by The Clovernook Center for the Blind and Visually Impaired

OR

I am the parent/legal guardian of _____

("Participant"), who is a participant in the Visionary Camp Program, hosted by The Clovernook Center for the Blind and Visually Impaired.

The undersigned understands that at times the Participant may be transported by a volunteer or paid staff member of Clovernook to various events or activities both on the premises at Clovernook and off-premises at various locations. I authorize this transportation. The undersigned Participant understands there are risks and physical dangers inherent in participating in the program, as well as risks and physical dangers in transporting the Participant to and from various activities and the Participant's home.

In consideration of the Participant being permitted to participate in the program, I do hereby fully waive, discharge, release and hold harmless Clovernook, its trustees, officers, agents, employees, and volunteers from any and all actions, liabilities, expenses, claims and demands of whatsoever kind, whether known or unknown (collectively, "Claims"), on account of any and all injuries, losses or damages, including consequential damages, which the Participant or the Participant's family members may sustain in connection with the Participant's participation in the program, or during the Participant's transportation by volunteers or paid staff members of Clovernook.

This release applies to any personal injury, property damage or wrongful death that may be suffered while participating in the program or during transportation to, from or in connection with the program, even if caused by the acts or omissions of others. The undersigned acknowledges that third-parties do participate in the program, and specifically

releases Clovernook from any claims arising out of the act or omission of such third-parties. This release is binding upon me, my spouse, my child and his/her personal representatives, assigns, heirs and next of kin.

I further state that I have carefully read this Release and know the contents thereof, and I affirm signing this Release as my own free act.

Parent/Legal Guardian: **Date:**

Print name:

Signature: **Phone**

(Signature of mother/legal guardian if participant is under 18 years of age.) I affirm that I have legal right to issue such consent.)

Address:

City: **State:** **Zip code:**

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MEDIA RELEASE

Date:

Consumer Name:

This release is valid FOR ONE YEAR from to

I hereby give permission do not give permission to Clovernook Center for the Blind and Visually Impaired to use my name and/or image in publicity and related materi-als. These materials may include, but not limited to, the following: brochures, press releases, newspaper articles, videos, social media or our website.

Consumer Signature Date

Witness Signature Date

If individual is a minor or has a legal guardian, the following must be completed as well.

Parent/Guardian Signature Date

Relationship to Consumer

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TRANSPORTATION AND CONSENT TO RELEASE INFORMATION

Consumer Name:

I hereby give consent for Clovernook Center for the Blind and Visually Impaired to transport my child/children to and from Clovernook Center for the Blind and Visually Impaired.

I hereby give permission to release programmatic information generated by Clovernook Center for the Blind and Visually Impaired to: for the purpose of furthering my rehabilitation programming in which I am or have been participating. **I understand that I can revoke this consent at any time and this information will be treated in a confidential manner.**

County Developmental Disability Services

Other (specify)

This release is valid from to

Information released is to be in the following format(s):

Written Report Email Verbal Video Tape Other (specify)

Signature of Individual Authorized to Consent

Date

Relationship if Other than the Consumer

Witness

Date