Nicklaus Children's Hospital | Dr. Moises Simpser VACC CAMP

* * * **SLEEPOVER CAMPER APPLICATION** * * *

(Please Print Clearly)

PERSONAL INFORMATION

NAME OF VENTILATION ASSISTED CHILD _____

D.O.B.____/____/____ Age _____ approx. Weight _____T-Shirt Size _____

LIST ALL OTHER MEMBERS OF THE IMMEDIATE FAMILY:

Name	Relationship	Age	Coming to Camp	T-Shirt size_
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____

FAMILY'S HOME ADDRESS:

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

EMAIL ADDRESS: _____ (PRIMARY MEANS OF COMUNICATION)

Parents' Daytime Phone Numbers (cell phones):

Mom - (____) _____ Dad - (____) _____

Campers are required to bring two individuals who are capable of assisting the camper throughout the term of the camp. Names of 2 individuals who will be assisting camper and relationship to camper:

1) _____ **2)** _____

VENTILATION ASSISTED CHILD'S MEDICAL INFORMATION

Primary Diagnosis: _____

Secondary/Other Diagnoses: _____

_____

VENTILATOR DEPENDENT? YES☐ NO☐ If yes:

When did child become ventilator dependent? _____

Hours per day on ventilator: _____

Type of ventilator (Brand Name and Model): _____

Current ventilator settings (**please fill out completely**):

Mode_____ Respiratory rate: _____ Sensitivity: _____

Peep: _____ High alarm _____ Low alarm _____ Volume _____ or Pressure _____

Frequency of circuit changes: _____

Company/therapist servicing ventilator: _____

_____

Address: _____

_____ Phone (_____) _____

TRACHEOSTOMY? YES☐ NO☐

If yes:

Type/size: _____

Suctioning frequency: _____

Changing frequency: _____

Please make sure to bring a backup tracheostomy to camp as well as a smaller size tracheostomy for ER purposes

OXYGEN? YES☐ NO☐

If yes: System currently used: Liquid _____ Gas _____ Concentrator _____

Amount: _____liters per minute Hours per day: _____

ALLERGIES: _____

MEDICATIONS (PLEASE NOTE THAT PARENTS ARE RESPONSIBLE FOR ADMINISTERING THEIR CHILD'S MEDICATIONS DURING THE DAYTIME AND AT NIGHT):

Type	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RESPIRATORY TREATMENTS (IF ANY):

Type	Dose/Frequency
_____	_____
_____	_____

FEEDING:

Feeds Orally? Yes ☐ No ☐

If yes: Table food ☐ Soft food ☐ Pureed ☐

Gastrostomy? Yes ☐ No ☐ if yes:

Type/size: _____

Formula (brand and flavor)/diet: _____

Amount and frequency of feedings:

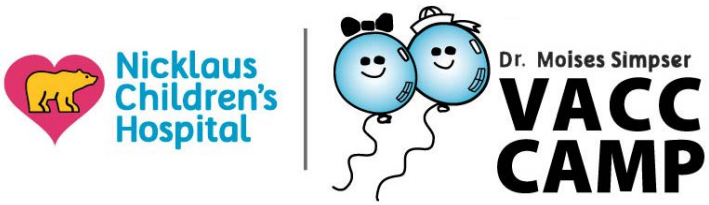
Bolus (amount and frequency): _____ or Continuous (ml/hr): _____

ELIMINATION:

Bowel/bladder control? Yes ☐ No ☐

Requires urine catheterization? Yes ☐ No ☐

If yes: Frequency: _____ Type/size: _____



CHILD'S PRIMARY PHYSICIAN:

Name _____ Specialty _____

Street _____ Phone (____) _____ Fax (____) _____

City _____ State _____ Zip _____

OTHER PHYSICIANS, NURSES OR RESPIRATORY THERAPISTS INVOLVED IN CHILD'S CARE (PLEASE INCLUDE CHILD'S PULMONOLOGIST**):**

Name _____ Specialty _____

Agency _____

Street _____ Phone (____) _____ Fax (____) _____

City _____ State _____ Zip _____

Name _____ Specialty _____

Agency _____

Street _____ Phone (____) _____ Fax (____) _____

City _____ State _____ Zip _____

Name _____ Specialty _____

Agency _____

Street _____ Phone (____) _____ Fax (____) _____

City _____ State _____ Zip _____

VENTILATION ASSISTED CHILD'S MOBILITY

Walks alone ☐ Needs assistance ☐

If needs assistance: Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐

If needs wheelchair: Manual ☐ Electric ☐

Position in wheelchair: Upright ☐ Reclined ☐

Paraplegic? ☐ Quadriplegic? ☐

Comment: _____

_____

_____

VENTILATION ASSISTED CHILD'S VERBAL COMMUNICATION Yes ☐ No ☐

If child does not communicate verbally, please explain in what manner child communicates

Comment: _____

_____

_____

VENTILATION ASSISTED CHILD'S EDUCATIONAL EXPERIENCE

Homebased ☐ School setting ☐ both ☐

Indicate current grade level and/or comment on type of classroom setting:

_____

_____

IS CHILD RECEIVING PHYSICAL, OCCUPATIONAL OR OTHER SPECIAL THERAPY? If yes,

Type of therapy:

_____

Agency _____ Phone (____) _____

Contact person

_____

Address

_____

City _____ State _____ Zip _____

(IF RECEIVING OTHER THERAPY, DESCRIBE AS ABOVE USING OTHER SIDE OF THIS PAGE.)

HAS CHILD EVER BEEN AWAY FROM HOME/HOSPITAL OVERNIGHT? Yes ☐ No ☐

If yes, explain occasion:

_____

_____

DESCRIBE CHILD'S RECREATION ACTIVITIES AND PERSONAL INTERESTS:

_____

_____

ADDITIONAL INFORMATION WE SHOULD KNOW ABOUT TO MAKE YOUR CHILD'S STAY AT CAMP MORE ENJOYABLE:

_____

_____

DOES ANY OTHER FAMILY MEMBER COMING TO CAMP HAVE SPECIAL NEEDS THAT WE SHOULD BE AWARE OF? IF YES, EXPLAIN:

_____

_____

_____

HOW DO YOU THINK YOUR VENTILATION ASSISTED CHILD AND YOUR FAMILY WOULD BENEFIT FROM THIS PROGRAM:

_____

_____

_____

IMPORTANT - IF YOU FAMILY IS INVITED TO PARTICIPATE:

WILL YOU TRAVEL TO OUR FIELD TRIPS IN OUR BUSES YES☐ NO☐

WILL YOU DRIVE YOUR OWN VEHICLE YES☐ NO☐

ATTACH A RECENT FULL-LENGTH PHOTOGRAPH OF YOUR VENTILATION ASSISTED CHILD.

We also require photos of each member of the family and/or caretaker attending for our ID badges.

I have provided the above information on behalf of my family and declare it to be accurate to the best of my knowledge. I hereby authorize any and all physicians, nurses, therapists and/or educators named in this application to discuss my ventilation assisted child's medical and developmental progress with VACC staff members for purposes of determining my child's capacity to participate in and benefit from the VACC Camp program. I understand that these contacts also serve to help plan camp activities to enhance my child's enjoyment of the program.

_____ _____

Signature of Parent/Guardian Signature of Parent/Guardian

Date: _____/_____/_____ Date: _____/_____/_____

General Waiver of Liability

Please fill one out for EACH person attending the Camp.

In consideration of Shake-A-Leg Miami, Inc. ("SALM") extending to me the opportunity to perform services for, utilize services of, participating in programs provided by SALM, I fully assume all risks that might arise, both known or unknown, and both inherent to the program or activity in which I am engaging and any risks that are not inherent, and waive all liability for all such risks, including without limitation any potential liability that SALM may have for its own negligence or the negligence of any of its agents, officers, directors, or employees, in connection with my participation in the program or activity, and in particular, without limitation, to the extent permitted by law, I and my heirs, representatives, executors, or administrators and my undersigned parent, guardian or aide (if applicable) remise, release, indemnify, acquit and hold harmless and forever discharge SALM and its directors, officers, employees, agents, instructors, volunteers, rescue and support personnel, from any and all claims and liability, including without limitation liability for SALM's and its directors', officers', employees', agents', instructors', volunteers', rescue and support personnel own negligence, and all obligations, damages, claims, causes of action, judgements, costs and charges which I may suffer or which may be incurred by me for any reason of any occurrence during my travel to and from the activity or program, and during my participation therein, whether resulting from any acts, omissions or negligence or from acts of God or nature. I also agree to assume liability for all and any damages to SALM property that is under my control while participating in any SALM activity.

During my participation, I hereby agree to comply with all SALM rules and regulations, applicable county and municipal ordinances, and with the laws of the State of Florida and the United States. I further hereby give my full and unconditional permission to SALM for the free use of my name, likeness, and image (including without limitation permission to use any photo and video in which I may appear) in any present or future media story, promotion, advertisement, or account of an SALM related program, event, or activity, including without limitation in connection with any present or future public relations or fundraising event or activity.

☐ **CHOICE OF LAW:** I understand and agree that the law of the State of Florida will apply to this contract.

☐ **I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.**

Adult Staff / Participants

Printed name: _____ Signature: _____

Youth Staff / Participants

I am the parent or legal guardian of the minor named below. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Minor's name: _____ Parent's name: _____

Relationship to minor: _____ Signature: _____

Shake-A-Leg Miami SINCE 1990

Date: _____

COVID -19 Disclosure

As you are most likely aware, research has shown and confirmed that risk of exposure to COVID-19 exists in all public places where people gather and are present. In accordance with the CDC (Centers for Disease Control and Prevention), it has also been confirmed that COVID-19 is a very contagious disease which can lead to severe illness or death. Senior citizens and people with underlying medical conditions are at a higher risk and especially vulnerable.

You are expected to make your decision to participate in the Moises Simper's VACC Camp with this information and knowledge.

By signing this letter, you are assuming all risks related to exposure to COVID-19.

We have read the above information concerning the risk of COVID-19 exposure; we fully understand the risk and take full responsibility of all consequences from being exposed.

Signatures of Parents of VACC Camper Family

Parent 1 signature: _____ Print name: _____

Parent 2 signature: _____ Print name: _____

Signature of Caretaker for the Camper

Caretaker Signature: _____ Print name: _____

Camper Name: _____ Date: _____

We look forward to seeing all of you at camp enjoying this wonderful opportunity and experience of being able to all get together!

Nicklaus Children's Hospital | Dr. Moises Simpser VACC CAMP

COVID -19 Vaccination Information Disclosure

Camper Family Members	Age		
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated
		☐ Vaccinated	☐ Not vaccinated

Please scan or take a photo of each COVID 19 vaccine certificates and submit those together with the filled application and all other forms included signed. If any member of the family is not vaccinated please explain why.

Signatures of Parents of VACC Camper Family

Parent 1 signature: _____ Print name: _____

Parent 2 signature: _____ Print name: _____

Camper name: _____ Date: _____

You can fax the application to 786-268-1765 and email the photos

You can scan and email the application and the photos to

bela.florentin@nicklaushealth.org

(Preferred method)

You can return completed application and photograph by mail to:

DR MOISES SIMPSER VACC CAMP
Nicklaus Children's Hospital
3200 S.W. 60th Court, Suite 203
Miami, FL 33155
(305) 662-8222 or 662-8380 Fax 786-268-1765