

***** 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:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Coming to Camp</u>	<u>T-Shirt size</u>
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____

FAMILY'S HOME ADDRESS:

Street _____

City _____ State _____ Zip _____

Phone (____) _____

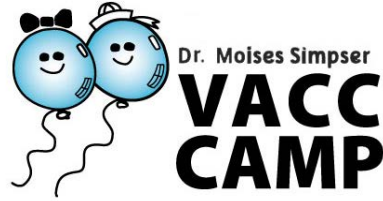
EMAIL ADDRESS: _____ (PRIMARY MEANS OF COMUNICATION)

Parents' Daytime Phone Numbers (cell phones):

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

Camper's 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: _____

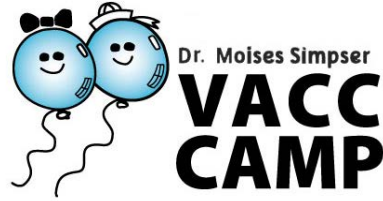
Please make sure to bring a backup tracheostomy to camp as well as a smaller size tracheostomy for ER purposes

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):

<u>Type</u>	<u>Dose/Frequency</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RESPIRATORY TREATMENTS (IF ANY):

<u>Type</u>	<u>Dose/Frequency</u>
_____	_____
_____	_____

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:

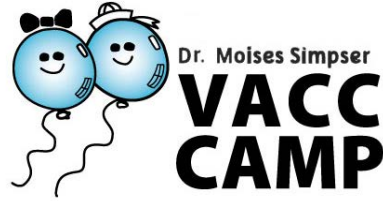
Bolus (amount and frequency): _____ or Continuous (ml/hr): _____

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**):**

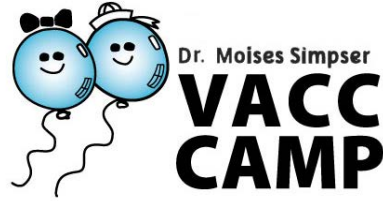
Name _____ Specialty _____
Agency _____
Street _____ Phone (____) _____ Fax (____) _____
City _____ State _____ Zip _____

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 _____

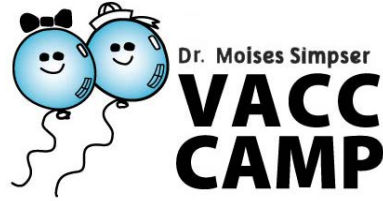
(IF RECEIVING OTHER THERAPY, DESCRIBE AS ABOVE USING OTHER SIDE OF THIS PAGE.)

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
Date: ____/____/____

Signature of Parent/Guardian
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:

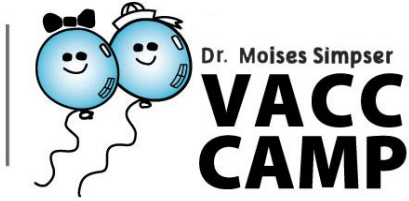
Parent's name:

Relationship to minor:

Signature:



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

bel.florentin@nicklaushealth.org

(Preferred method)

You can return completed application and photograph by mail to:

**DR MOISES SIMPSON 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**