November 1, 2017
Dear Friends,

We are offering day camp during Winter Break. We are offering various life experiences for individuals with disabilities starting at age 8 and up. Our program is located at 5200 Lake Rd. Medina, Ohio. We will be providing access to the community through scheduled outings and field trips.

The purpose of our program is to provide opportunities for individuals with disabilities in a home-like setting to prepare for a future of independent living. By providing these experiences before individuals move into their own homes we hope to lay the foundation for more independence and an easier transition.

Please review the enclosed packet carefully and the **deadline dates.** Please give detailed information regarding your campers' needs. This will help us provide a safe and fun-filled experience for everyone. All forms must be completed and submitted by December 15,,2017 and will be accepted on a first-come first-serve basis. Please send completed forms to: 1120 North Huntington St. Medina, Ohio 44256. Information concerning fees and financial aid for Medina County residents is included in the attached packet. We accept private pay, Family Resources, IO, Level One and SELF waiver. Please note that scholarships are available.

Checklist of items due by December 15, 2017
*Registration Form
*$75.00 Non-Refundable Deposit for each week of registration
*Parent/Guardian/Camper Consent form
*Activities of Daily Living Form
We will send a confirmation to you with the date(s) your camper is due to attend. If for some reason you need to cancel your camper's session, please let us know as soon as possible. We hope you join us for a new Life Skills Camp experience

Sincerely,

Sharon D. Biggins
Life Steps Director

5200 Lake Rd. Medina, Ohio 44256
Phone: 330-591-4434

Camp Registration Form
DUE: December 15, 2017

Name of Camper____ ___Male ___Female

Camper's Address_______ _________________________________ Date of Birth:________________

Parent/Guardian____ Phone:__________ ___________

Email:____ Cell Phone:__________________

Case Manager:____ Phone:______________________

EMERGENCY CONTACT

Contact Person:____ Phone:______________________

Relationship to Camper:_________________________________ Cell Phone:__________________

_____ December 21-22
_____ December 26-29
_____ January 1-2

Amount of deposit $__________($75.00 non-refundable deposit)

Indicate form of payment _____Check enclosed _____Family Resources _____Waiver

Person, agency or organization responsible for payment:_______________________________________

Address:____

Return registration forms with deposit to :
Medina Creative Accessibility
Life Steps
1120 North Huntington St. Medina, Ohio 4425
Camp Registration – Continued

Camper's Name:____

Please describe camper's disability/special needs:______________________________________

Allergies: Please list all known allergies of camper

Medication Allergies:	Please describe reaction and management of the reaction:
Food Allergies:	
Other Allergies:	

Does Camper have any of the following?

___Yes ___No IEP or Behavior Plan

___Yes ___No Require communication assistance? List:_______________
____

Explanation to enhance this camper's experience:______________________

List some activities the camper enjoys, additional comments or suggestions:

Camp Medical Record
This is a required form – Due December 15, 2017
To Be Completed By A Physician

A completed form is required for all campers.

If the camper is taking prescription medication an exam must be performed within 12 months of arrival at camp. We will also accept a copy of another examination signed by camper's doctor if within these time frames.

Please Print Carefully:
Camper's Name____

Date of Birth:______________________________Age:______________________

Please list **Allergies** if any:____

Parent/Guardian:___________________________Phone:_____________________

PHYSICIAN STATEMENT

Camper's Name____

TETANUS SHOT CURRENT (Within last 10 years): Yes_____ No_____

Name of Physician prescribing medication:________________Phone:_______________

Camper is to take Medications while at Life Steps as follows:

Name of Medication	Dosage and Frequency	Dispensing Method

Medical Diagnosis:____

Please list all health concerns that staff should be aware of:_________________________

I certify the above applicant is fit to participate in the Respite Camp program and is free of communicable disease:

Physician Signature:____________________________________Date:________________

APPROVED PRN FORM

TO BE COMPLETED AND SIGNED BY A PARENT OR GUARDIAN

Camper's Name:_____________________________ Date:_______________

Allergies:____

Approved PRN Medications:

SYMPTOM	MEDICATION	DOSAGE
Headache, Pain, Fever	Acetaminophen	Per product recommendation on campers age and weight
Muscle aches, menstrual cramps	Ibuprofen	Per product recommendation on campers age and weight
Nasal Congestion	Sudafed	Per product recommendation on campers age and weight
Sore Throat	Chloraseptic	Per product recommendation on campers age and weight
Stomach Ache, Indigestion	Pepto Bismol	Per product recommendation on campers age and weight
Sun Protection	Sun Block SPF #30	Per product recommendation on campers age and weight
Sunburn	Americaine Spray	Per product recommendation on campers age and weight
Dry Skin	Moisturizing Lotion	Per product recommendation on campers age and weight
Cuts, Abrasions	Hydrogen Peroxide Bacitracin Ointment	Per product recommendation on campers age and weight

Parent or Guardian Signature: ___________________ Date:______________

LIFE STEPS Camp
Consent Form

Camper's Name:____

___Yes ___No I authorize Life Steps staff to act for me in a responsible manner in case of an emergency that requires medical care.

___Yes ___No I authorize the Director or authorized MCL staff to administer the campers medication as listed on their medical form.

___Yes ___No I give permission for staff to transport camper for outings and activities.

___Yes ___No I give MCA permission to photograph or video tape Camper while they are engaged in activities involved with camp. I also give permission for the public dissemination of this material for education and promotional purposes.

I authorize the following individuals listed to pick up my camper.

____

____

____

Parent or Guardian Signature_______________________ Date:__________

ACTIVITIES OF DAILY LIVING FORM - DUE December 15, 2017

CAMPER'S NAME: ____________________________DATE___________

Please be as specific as possible:

EATING/DRINKING:

___Independent
___Difficulty swallowing
___Needs food cut up and special plate or utensil (list)
___Must be fed
___Can use straw
Explain:________________________________
____
____

SWIMMING:

___ Requires Life Jacket or Floatation Device

MOBILITY:

___Walks independently
___Walks: Needs assist w/ slopes, rough areas
___Wheelchair: Independent
___Wheelchair: Assist w/ slopes, rough areas
___Wheelchair: Needs assist at all times
___Wheelchair: Long distances only
___Requires rest during the day

DRESSES/UNDRESSES:

___Independent
___Needs partial assistance
___Needs total assistance
Explain:________________________________
____
____
____

BATHROOM:

___Independent
___Bladder incontinence
___Bowel incontinence
___Requires prompting for toileting
___Needs transfer to toilet
___Needs assistance wiping
___Needs total assistance
___Uses toilet chair
___Uses special undergarments
___Requires assistance with menstrual care

DIET:

___Normal
___Low salt
___Low calorie – Total calories__________
___Diabetic – Total calories____________
___Knows limits
___Chopped food
___Blended/pureed food
List food restrictions:____________________
____
List food allergies:______________________
____

TRANSFERS:

Camper weighs:__________lbs.
___Can make independently
___Pivot transfers/can bear weight on feet
___Must be lifted *
Please explain:__________________________
____
* must provide own hoyer, if needed.

BATHING:

___Independent
___Needs partial assistance
___Needs total assistance
___Uses shower
___Uses shower chair
Explain:_________________________________
____
____
____

ADAPTIVE EQUIPMENT:

___Glasses
___Contacts
___Hearing Aid
___Dentures
___Other
(list)____________________________
____
____
____
____