MEDINA CREATIVE EXCURSIONS
Creating Memories to Last a Lifetime

224 North Court St. Suite 200
Medina, Ohio 44256
330-591-4434

August 29, 2016
Dear Friends,
Medina Creative Excursions was created to provide exciting and exhilarating vacations for adults with developmental disabilities that will make memories to last a lifetime. Each vacation is specially designed to provide unique experiences that are all inclusive, including supervision by trained staff.

Many of the adults who have attended our Life Steps Life Skills Training Program have graduated our program, but still want to have the fun and excitement that Life Steps brought to their summers. We are offering two weeks of vacations this summer.

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 September 19, 2016 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. Please note that partial scholarships might be available.

Checklist of items due by September 19, 2016
*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) you are scheduled to attend. If for some reason you need to cancel your vacation, please let us know as soon as possible. We hope you join us for a new Medina Creative Excursions vacation experience.

Sincerely,

Sharon D. Biggins
Director of Educational and Therapeutic Programs

MEDINA CREATIVE ACCESSIBILITY
Removing the Barriers
224 North Court St. Suite 200
Medina, Ohio 44256
330-591-4434

Vacation Form Due
Sept 19, 2016

Name_____ ___Male ___Female

Address_____ Date of Birth:_____

Parent/Guardian_____ Phone:_____

Parent Email_____ Cell Phone:_____

Case Manager:_____ Phone:_____

EMERGENCY CONTACT

Contact Person:_____ Phone:_____

Relationship to Individual:_____ Cell Phone:_____

_____ Hocking Hills Sept. 30-October 2

Amount of deposit $_____($75.00 non-refundable deposit for each week)

Indicate form of payment _____Check enclosed _____Family Resources _____Waiver

_____School _____Family First _____Campership

Person, agency or organization responsible for payment:_____

Address:_____

Return registration forms with deposit to:
Medina Creative Accessibility
Medina Creative Excursions
1120 North Huntington St. Medina, Ohio 44256

Registration – Continued

Name:_____

Please describe 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 Individual have any of the following?

___Yes ___No ISP or Behavior Plan

___Yes ___No Require communication assistance? List:_____
_____

Explanation to enhance your experience:_____

_____

_____

_____

_____

List some activities you enjoy, additional comments or suggestions:

_____

_____

_____

_____

Medical Record
This is a required form – Due September 19, 2016
To Be Completed By Physician

A completed form is required for all individuals.

If you are 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 your doctor if within these time frames.

Please Print Carefully:
Name:_____

Date of Birth:_____ Age:_____

Please list **Allergies** if any:_____

Parent/Guardian:_____ Phone:_____

PHYSICIAN STATEMENT

Patient's Name_____

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

Name of Physician prescribing medication:_____Phone:_____

Individual is to take Medications while on vacation 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 Medina Creative Excursions program and is free of communicable disease:

Physician Signature:_____Date:_____

APPROVED PRN FORM

TO BE COMPLETED AND SIGNED BY INDIVIDUAL OR GUARDIAN

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

Individual or Guardian Signature: _____ Date:_____

Medina Creative Excursions
Consent Form

Individual's Name:_____

___Yes ___No I authorize Medina Creative Excursions to act for me in a responsible manner in case of an emergency that requires medical care.

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

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

___Yes ___No I give MCA permission to photograph or video tape the individual while they are engaged in activities involved with MCE. 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 the individual.

_____

_____

_____

Individual or Guardian Signature_____Date:_____

ACTIVITIES OF DAILY LIVING FORM - DUE Sept 19, 2016

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)_____
_____
_____
_____
_____

MEDINA CREATIVE ACCESSIBILITY
Removing the Barriers

SCHOLARSHIP APPLICATION

Assistance for Medina Creative Excursions may be available for those unable to attend for financial reasons. Please indicate the amount you are able to pay in the space provided below. Partial payment allows us to grant scholarships to more individuals. To apply for this assistance, please fill in the following information and a representative will contact you.

Please indicate amount you are able to pay towards fee: $_____
Is the individual eligible for:
Family Resources Yes_____ No_____

If yes, the amount applied toward Life Steps Camp: $ _____
Individuals Name:
_____

Address: _____

Phone: _____
Email:_____
Reason for applying: _____

_____

_____