LIFE STEPS
Training Today for Independence Tomorrow

Registration Packet Due
May 7, 2021

February 26, 2021
Dear Friends,

We are offering various life experiences for individuals with disabilities starting at age 8 and up at our Life Steps Camp this summer. Due to the COVID-19 pandemic and regulations put in place from the state, our program is being held at our training facility at 301 N. State Rd. Medina, Ohio. The facility has an open plan for easy movement throughout. At this time, group numbers are limited to 12 campers each day. We will be providing access to the community through scheduled outings and field trips as available within COVID-19 guidelines. All campers will also have the opportunity to participate in therapeutic horseback riding at Medina Creative Therapy Ranch. Lessons will be held outdoors as long as weather permits in order to ensure the health and safety of participants during the COVId-19 pandemic. (If your child plans to ride horses you must fill out the enclosed Medina Creative Therapy Ranch horseback riding packet also)

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 May 7, 2021. These will be accepted on a first-come first-serve basis. Please send completed forms to: 224 N. Court 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 and Level One Waiver, and ESY (extended school year). Please note that scholarships are available.

Checklist of items due by May 7, 2021
*Registration Packet
*$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 experience

Sincerely,

James B. Kirby
Medina Creative Accessibility
Director of Services
jay@medinacreativeaccessibility.com

330-635-6918

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CAMPER REGISTRATION

Please mark an "X" on all weeks that your camper wishes to attend.

Camper's Name_____

_____**Forest Friends** June 7-11
_____ **Western Roundup** June 14-18
_____ **Tom Sawyer & Huck Finn Adventures** June 21-25
_____ **Lights, Camera, Action!** June 28-July 2
_____ **Cooking in the USA** July 5-9
_____ **Willy Wonka** July 12-16
_____ **Frontier Days** July 19-23
_____ **Summer Olympic Sports Week** July 26-30
_____ **The Secret Garden** August 2-6
_____ **Challenge Week** August 9-13

Amount of deposit $_____($75.00 non-refundable deposit for each week)(Balance due by May 7, 2021)

Indicate form of payment _____Check enclosed _____Family Resources _____Waiver

_____School _____Family First _____Campership

Person, agency or organization responsible for payment:_____

_____

Person, Agency, or Organization Responsible for payment Address:_____

_____

Return registration forms with deposit to:
Medina Creative Accessibility
Life Steps
224 North Court St. Medina, Ohio 44256

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EMERGENCY MEDICAL FORM (Page 1)

Camper Name: _____ (Last / First / M.I.)	Name / location of Preferred Hospital: _____
Phone Number: _____	Individual own guardian: ☐ Yes ☐ No
Date of Birth: _____	
Current Address _____ (Street / City / State / Zip / Unit #)	
E-Mail: _____	

Existing condition(s) for which medical interventions may be needed:

Existing Condition	Intervention

Emergency Relief Medications

Medication Name	Reason for Medication

Dietary and Allergen Information

Dietary Restrictions:

☐ Yes, please list: _____ ☐ No

Individual's allergies (food, medication, environmental, insect stings, etc.)

☐ Yes, see below: ☐ No known allergies

Allergen	Symptoms

Does the Individual Hold a Do-Not-Resuscitate (DNR) Order? (If answering "Yes", Medina Creative Accessibility will require a copy of the DNR order form prior to service delivery)

☐ Yes, DNR Comfort Care (DNRCC) ☐ Yes, DNR Comfort Care – Arrest (DNRCC-Arrest) ☐ No

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EMERGENCY MEDICAL FORM (Page 2)

Camper's Name: _____ (Last / First / M.I.)	Name of Preferred Hospital _____

Authorization for Emergency Medical Treatment

I give my permission to Medina Creative Accessibility to seek medical care if needed in case of injury or illness. I also give my permission to Medina Creative Accessibility to act on my behalf in the event of an emergency and to administer CPR/First Aid if needed. I understand that if there is a DNR order in place, Medina Creative Accessibility will follow the DNR order.

Signature of Applicant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

In Case of an Emergency Please Contact

Name: _____ (Last / First)	Phone No.: _____

Current Address _____
(Street / City / State / Zip / Unit #)

E-Mail: _____

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CAMPER INFORMATION

Camper's Name:_____
Last First M.I.

Brief Description of Camper's Disability/Special Needs

_____
_____
_____

Does the Camper Have any of the Following?

Individual Education Plan (IEP)	◯ Yes	**Name of School District:** _____
Behavioral Support Plan (BSP)	◯ Yes	**Reason for Behavioral Support Plan:** _____ _____ _____
Individual Support Plan (ISP)	◯ Yes	**Name of County the ISP is with:** _____ **Name of Service & Support Administrator:**_____ _____
Seizure Plan	◯ Yes	**Please include a copy of the Seizure Plan outlined and signed by the Camper's Physician with this application.**
Require Communication Assistance	◯ Yes	**Description of communication devices, programs, or strategies:** _____ _____ _____ _____

Explaination to Enhance this Camper's Experience

_____
_____
_____
_____
_____
_____

List Some Activities the Camper Enjoys, Additional Comments, or Suggestions

_____
_____
_____
_____
_____

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Camp Medical Record
This is a required form – Due May 7, 2021
To Be Completed By 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 Life Steps program and is free of communicable disease:

Physician Signature:_____Date:_____

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Physician Order Form for Medication Administration
This is a required form – Due May 7, 2021
To Be Completed By Physician For Medications That Need Administered During Camp Hours

Individual's Name: _____ DOB: _____

Are there any Advanced Directives for this individual? □ Yes / □ No. If so, please attach.

Ordering Physician: _____

Physician Contact Number: _____

Allergies: _____

Dietary Restrictions: _____

Medical History: _____

_____

_____

Medications/Treatments:
Please indicate the reason(s) the individual is taking each medication. For PRN medications, please indicate parameters in which the medication should be given. Please include any OTC medications which should be administered on a scheduled/PRN basis by delegated non-licensed staff.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician's Signature: _____
Date: _____
Physician orders are valid for one (1) year from the date of signature.

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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:_____

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LIFE STEPS
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 Camp Director or authorized staff to administer the campers medication as listed on their medical form.

___Yes ___No I give permission for Life Steps 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. 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:_____

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ACTIVITIES OF DAILY LIVING FORM - DUE May 7, 2021

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

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)_____
_____
_____
_____

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MEDINA CREATIVE ACCESSIBILITY
Removing the Barriers

LIFE STEPS
CAMPERSHIP APPLICATION

Assistance 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 camperships to more individuals. To apply for this assistance, please fill in the following information and a representative will contact you.

(Please Circle) Camper will attend: Week 1 2 3 4 5 6 7 8 9 10
Please indicate amount you are able to pay towards camp fee:
$_____

Waiver funding: Yes _____ No_____
Family Resources Yes_____ No_____

If yes, the amount applied toward Life Steps Camp: $ _____
Camper's Name:
_____

Address: _____

Phone: _____

Email:_____

Reason for applying: _____

_____

_____

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LIFE STEPS FINANCIAL RESPONSIBILITY FORM

I fully understand that if a funding source fails to pay for the cost of Life Steps Camp I will be held responsible for any and all unpaid balances.

_____ _____
Signature Date

_____ _____
Guardian Signature Date