



Midnight Farm Day Camps
 Community Living Opportunities, Inc.
 2125 Delaware Street
 Lawrence, KS 66046

CAMPER INFORMATION

Last Name: _____ First Name: _____ NickName: _____

Street Address: _____ City, State: _____ Zip Code: _____ Gender: M F

PARENT/GUARDIAN INFORMATION (place check mark next to address to which acceptance information should be sent)

Custodial Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Street Address: _____ City, State: _____ Zip Code: _____

2nd Custodial Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Street Address: _____ City, State: _____ Zip Code: _____

ALTERNATIVE EMERGENCY CONTACTS (other than parent/guardian listed above)

Name: _____ Relationship to Camper: _____ Phone Number: _____

2010 CAMP DATES

Please *indicate the camp activities for which the applicant is applying.*

Camp Dates	Parent Training	Therapeutic Horseback Riding
Kids Camp <input type="checkbox"/> March 15-20 th <input type="checkbox"/> June 12 th -13 th <input type="checkbox"/> June 26 th -27 th <input type="checkbox"/> July 26 th -30 th Young Adult Camp <input type="checkbox"/> May 24 th -27 th	Available at Camp Sessions <input type="checkbox"/> March 15-20 th <input type="checkbox"/> July 26 th -30 th	Available at Camp Sessions <input type="checkbox"/> March 15-20 th <input type="checkbox"/> July 26 th -30 th <input type="checkbox"/> May 24 th -27 th
FEE: Monday – Friday 9:00am to 4:00pm Cost for child: \$250	FEE: Free if your child is attending camp (including lunch and snack) \$80 if attending parent training without a child attending camp (including lunch and snacks): \$80	Horseback riding with a NARHA certified instructor and trained camp staff supporting your child while riding Cost: \$25 per ride Maximum number of rides is one ride per day (4 rides = \$100)
Camp Date Desired:	Attending Parent Training:	Number of Riding Sessions:

NATURE OF DISABILITY

(Check all that apply)

- Cerebral Palsy
- Spina Bifida
- Autism
- Asperger's Syndrome
- Epilepsy/Seizure Disorder
- Genetic/Chromosomal
 - Down Syndrome Other:
 - Fragile X
- Intellectual Disabilities
 - Level: mild
 - moderate
 - Severe/profound
- Attention Deficit Disorder/ADHD
- Learning/Developmental Delay

- Speech-Language/Voice Dysfunction
- Social/Psychological
- Central Nervous System Injury/Disorder
- Multiple Sclerosis
- Behavior Disorders
- Spinal Cord Injury
 - Quadriplegic
 - Paraplegic
 - Other
- Visually Impaired
 - Partial
 - Total
- Hearing Impaired
 - Partial
 - Total

- Orthopedic Impairment(s) at Birth
- Postural Disorders
- Heart, Circulatory, Respiratory Defect
- Asthma
- Psychosis
- Peripheral Nerve Injury/Disorder
- Bleeding/Clotting disorders
- Skin and Cellular Tissue Disorder
- Muscular Dystrophy
- Allergic/Metabolic/Nutritional Diseases
- Cystic Fibrosis
- Diabetes
- Other Disabilities (please list):

GENERAL BACKGROUND

MOBILITY:

- Walks independently Uses Crutches Uses Walker Mobility
- Uses wheelchair (manual): can camper push self? Yes No
- Uses wheelchair (power)

TRANSFERS

- No assists needed Can camper bear weight when standing? Yes No
- Needs assistance (explain transfer):

ASSISTIVE DEVICES

- None Helmet AFO's Prosthesis
- Oxygen Machine Glasses Hearing Aid Other:

COMMUNICATION

Does camper have difficulties expressing thoughts or wants? Yes or No
Please explain: _____

Does camper use the following devices?

- Facilitated Communication Communication board Sign language
- System of gestures (please describe): _____

PERSONAL CARE

Eating Assistance:

- No assistance needed Partial assistance needed Total assistance needed
- Special utensils Please provide details: _____

Diet:

- Normal Chopped food Blended/pureed Low calorie Low salt
- Diabetic Special diet *Attach list of special diet so we may determine if we can meet applicant's needs.
- Food allergies(list): _____

Restroom Assistance:

- Always Sometimes Needs reminders Incontinent
- Needs assistance On a schedule: if yes please describe _____
- Uses disposable undergarments

Dressing Assistance:

- Partial Assistance Total Assistance Needs help with (belt, zipper, buttons, shoes)

HEALTH INFORMATION AND RESTRICTIONS

Please list any medications applicant uses: _____

Yes No Type Frequency

Seizures: Describe any warning signs (aura) before seizures

* If camper is prescribed seizure medication they **MUST** bring the medication to camp.

None Hay Fever Poison Ivy Insect Stings
 Asthma Penicillin Other:

Allergies: Describe allergic reactions

Please summarize applicant's medical history: _____

Has applicant ever required any psychiatric treatment/counseling or hospitalizations? Yes No Please summarize (include dates): _____

Does applicant have a shunt? Yes No List special instructions: _____

Does applicant menstruate? Yes No

List feminine products used: _____

Special treatment for cramps?

Do they need assistance with products: Yes No

Please list any activities the participant may NOT participate in or attach precautions or special instructions for routine camp activities: _____

SOCIAL BACKGROUND

School/Place of Employment: _____ Grade Level: _____

Can applicant read? Yes No

Does applicant have any special behavior problems? Yes No

When do behavior problems occur? _____

Describe effective methods to control difficult behaviors: _____

Please list any fears the applicant may have: _____

Please list any activities the applicant dislikes: _____

What hobbies or activities does the applicant enjoy at home or school: _____

Please add any other information you feel would be helpful in providing the best experience for the applicant at camp: _____

INSURANCE

Is the applicant covered by hospitalization insurance? Yes No

Carrier: _____ Policy or Group Number: _____

Medicare Number: _____ Medicaid Number: _____

*A copy of Insurance/Medicaid/Medicare card or Military ID card must accompany this application.
Please supply a copy of **BOTH FRONT and BACK** of the card.*

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*Place copy of **FRONT** of Insurance Card
here*

*Place copy of **BACK** of Insurance Card
here*

MEDICAL FORMS and PAYMENT

All 2009 Camp Registration Form, Medical Form and full payment must be received 15 days prior to the first day of the camp session the camper will be attending.

WAIVER AND RELEASE

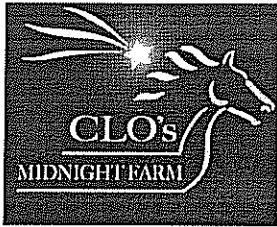
The following section must be signed in ink by the adult applicant or legal guardian of the juvenile applicant before the application can be processed:

- (1) This application has my approval. While Midnight Farms, a program of Community Living Opportunities (CLO) will take every reasonable precaution, it is agreed that Community Living Opportunities is not legally responsible for any accidents, incidents or injuries that may occur during the camp session, assumes no responsibility for applicant's personal property and is released from liability for any accident, incident or injury except as may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted by myself or physician.
- (2) The below signed individuals agree to be photographed and/or videotaped by CLO while engaging in activities at Midnight Farm Camp with the understanding that said media may be used for the purpose of training and marketing. This includes but is not limited to printed material, web site material and promotional presentations.
- (3) I attest that all information provided in these application materials including the application, medical examination summary, payment form and any supplemental items attached are true and correct to the best of my knowledge.

Legal Guardian/Parent: _____

Date: _____

No camper will be discriminated against because of race, national origin, sex, age, religion or disability



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PHYSICIAN'S MEDICAL EVALUATION, STATEMENT and MEDICAL HISTORY
 This form must be updated annually

Rider's Name: _____ Date: _____

Address: _____ Birth Date: _____

Name of [] Parent or [] Guardian: _____

Primary Diagnosis: _____

ONSET (Please check one): [] Birth [] Childhood [] Adolescence [] Adulthood

Secondary: _____ Tertiary: _____

Height: _____ Weight: _____ Tetanus Shot: [] Yes [] No Date of most recent shot: _____

PLEASE LIST ALL CURRENT MEDICATIONS:

1. _____ taken for: _____
2. _____ taken for: _____
3. _____ taken for: _____
4. _____ taken for: _____

Type of seizure: _____ Controlled? _____ Avg. # of seizures per month: _____

MOBILITY: Ambulatory: ___ Yes ___ No;
 Wheelchair ___ Yes ___ NO; Crutches ___ Yes ___ No; Walker/Cane; ___ Yes ___ No; Braces ___ Yes ___ No

Please describe any special medical or physical precautions or adaptations needed:

Signature of Adult Rider or Parent/Guardian if under 18 or have a guardian _____ DATE _____

PHYSICIAN'S STATEMENT (Signature Required)
(Please review and complete the information on page 2)

To the best of my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will consider the medical information I have provided on the next page to determine their ability to meet the individual's existing health conditions, precautions and requirements.

Physician Name (please print): _____

Physician Signature (REQUIRED): _____

Office Address: _____

Office Phone: _____ Date: _____

This information MUST be completed by the Physician

Rider's Name: _____

Physician, please note—The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, please note whether these conditions are present, and to what degree. Please be as specific as possible so that we may best serve the rider's needs. (Circle conditions as needed and add comments below.)

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial instabilities
Scoliosis (>30, riding is contraindicated)
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical

Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Neurologic

Hydrocephalus/shunt
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to spinal cord injury
Seizure Disorders

Secondary Concerns

Behavior Problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

Other Condition(s) not listed above: _____

Comments related to any existing health conditions:

Riders with Down Syndrome – Please Note:

Due to the nature of the activity of horseback riding, individuals diagnosed with Downs Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

- a) Most recent cervical x-ray for AAI: []NegativeDate of x-ray _____
- b) Annual cervical exam for AAI: []Negative ... Date of Exam _____

Does the rider have a health concern and/or surgeries in any of the following areas? If yes, please explain:

AREA	YES or NO	Explanation (please provide details)
Auditory	_____	_____
Visual	_____	_____
Speech	_____	_____
Cardiac	_____	_____
Circulatory	_____	_____
Pulmonary	_____	_____
Neurological	_____	_____
Muscular	_____	_____
Orthopedic	_____	_____
Allergies	_____	_____
Learning Disabilities	_____	_____
Mental or Psychological Impairment	_____	_____
Other:	_____	_____