NWSRA DAY CAMP REGISTRATION

Would you like to be added to our mailing/email list? ☐

If registering more than one participant, please complete an additional form.
If you wish to provide vaccination status, please email proof of vaccination to office@nwsra.org.

PARTICIPANT'S INFORMATION:

Participant's Name (Legal Last) _____ (Legal First) _____ (Preferred) _____

Address_____ City_____ Zip _____

Park District _____ Township_____ If you **DO NOT** wish to give photo/video permission, please initial here _____

Home Number _____ Cell Number _____ E-mail _____

Gender _____ Age _____ Birthdate _____ Diagnosis _____ Ethnicity _____ T-Shirt Size _____

Residential Facility Name _____ In case of emergency at program please contact _____

School/Day Center attending _____ Home School District (If different from attending) _____

Teacher/QIDP _____ E-mail _____ Phone Number _____

Permission to contact above, please initial here _____ Participant is own guardian ☐ Yes ☐ No Staffing Ratio: ☐ 1:1 ☐ 1:2 ☐ 1:4 ☐ Independent

PARENT/GUARDIAN INFORMATION:

Parent/Guardian 1 (Legal Last) _____ (Legal First) _____ Guardian Type _____

Address (if different from above) _____ City _____ Zip _____

Primary Contact Method ☐ Home ☐ Cell ☐ Work ☐ E-mail _____

Home Number _____ Cell Number _____ Work Number _____

Parent/Guardian 2 (Legal Last) _____ (Legal First) _____ Guardian Type _____

Address (if different from above) _____ City _____ Zip _____

Primary Contact Method ☐ Home ☐ Cell ☐ Work ☐ E-mail _____

Home Number _____ Cell Number _____ Work Number _____

☐ Check this box to opt-in to text communication ☐ I agree for NWSRA staff to apply sunscreen and /or bug spray to my child

EMERGENCY CONTACT	NAME OF AUTHORIZED INDIVIDUALS FOR PICKUP	PHONE NUMBER(S)
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		

SAFETY INFORMATION

NWSRA is committed to conducting its recreation programs and activities in a safe manner and holds the safety of participants in high regard. NWSRA continually strives to reduce risks and insists that all participants follow safety rules and instructions that are designed to protect the participants' safety. However, participants and parents/guardians registering for the programs listed above must recognize that there is an inherent risk of injury when choosing to participate in recreational programs. You are solely responsible for determining if you or your participant are physically fit and/or skilled for the activities contemplated by this agreement.

RELEASE OF ALL CLAIMS AND ASSUMPTION OF RISK

Please read this form carefully and be aware that in signing up and participating in the above identified programs, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your participant might sustain as a result of participating in any and all activities connected with and associated with said programs (including transportation services, when provided.) Recreational programs and activities are intended to challenge and engage the physical, mental and emotional resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when participating in any recreational program or activity. Understandably, not all hazards and dangers can be foreseen. Depending on the particular activity, participants must understand that certain risks, dangers and injuries due to inclement weather, slipping, falling, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, participant misconduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and all other circumstances inherent to indoor and outdoor recreational activities/programs exist. In this regard, it must be recognized that it is impossible for NWSRA to guarantee absolute safety. I recognize and acknowledge that there are certain risks of physical injury to participants in these programs, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my participant or I may sustain as a result of said participation. I do hereby fully release and forever discharge NWSRA from any and all claims for injuries, damages, or loss that my participant or I may have or which may occur to me or my participant and arising out of, connected with, or in any way associated with these programs.

I have read and fully understand the above safety information, and release of all claims and assumptions of risk. If registering on-line, fax or e-mail, your electronic or photocopy signature shall substitute for and have the same legal effect as an original form signature.

Form Prepared by _____ Relationship to Participant _____

Signature _____ Date_____ Print Name_____
Adult participant if own guardian or parent/guardian

For enhanced safety measures, photos will be required for all participants in programming. If you have not submitted a photo previously please email it to office@nwsra.org

NWSRA DAY CAMP REGISTRATION

PARTICIPANT NAME _____ **SEASON/YEAR** _____

PROGRAM #	PROGRAM NAME	MEDS TAKEN AT PROGRAM	PICK UP LOCATION (PAGE 13)	DROP OFF LOCATION (PAGE 13)	PROGRAM FEE (PAGE 13)	TRANS FEE (PAGE 13)	TOTAL FEE (PAGE 13)
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					
		☐ YES ☐ NO					

AFTERCARE REGISTRATION

Participant Name: _____

DATES	PROGRAM #	TRANSPORTATION (Select weeks needed)	CIRCLE DAYS ATTENDING Aftercare Only
June 10 - June 14	4051		M T W TH F
June 17 - June 21	4052		M T W TH F
June 24 - June 28	4053		M T W TH F
July 1 - July 3 NOT July 4 & 5	4054		M T W
July 8 - July 12	4055		M T W TH F
July 15 - July 19	4056		M T W TH F
July 22 - July 26	4057		M T W TH F
July 29 - August 2	4058		M T W TH F

You may charge your registration. Please check one.

☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Account # _____ Expiration Date _____/_____ CVC#_____

If requesting auto withdrawal payment plan, please check here ☐ By checking the automatic withdrawal box on the registration form, I authorize NWSRA to automatically withdraw payments according to the schedule listed within the registration information section of the brochure.

All past balances must be paid in full prior to registration.

Total Program Cost $_____

Program Credits $_____

SLSF Donation $_____

Total Enclosed $_____

Make check payable to NWSRA

I DO NOT NEED TO UPDATE:

Personal care, medication or medical conditions/needs information: ☐

Send us your registration form!

MAIL IN: NWSRA 3000 W. Central Road, Suite 205 Rolling Meadows, IL 60008

FAX: 847/392-2870 Call office to ensure receipt of fax.

E-MAIL: E-mail new fillable registration form to office@nwsra.org

I NEED TO UPDATE:

Personal care, medication or medical conditions/needs information: ☐

Complete the following applicable pages.

What are the participant's preferred activities? How does participant react?

What activities does the participant not prefer? How does participant react? Effective staff support/response?

What are the effective transition techniques (timers, countdowns)?

SENSORY: What kind of sensory experiences does participant seek or avoid?

Sound	Touch	Visual	Taste	Smell	Movement
☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids

COMMUNICATION:

Is English the participant's primary language? ☐ Yes ☐ No (If no, list primary language):

How does participant communicate? (verbal, sign language, eye movement, picture boards, iPad, etc.)

Is participant capable of giving staff instruction or should staff rely on guardian comments only? (i.e.:food requests, personal care information)

ASSISTIVE DEVICES:

Wheelchair ☐ Braces ☐ Canes ☐ Walker ☐ Glasses ☐ Sign Language Assistance ☐ Hearing Aids ☐ Augmentative Communication Device

Additional _____ If using a wheelchair is participant capable of transferring? ☐ Yes ☐ No Wheelchair Type ☐ Manual ☐ Power ☐ Amigo

Does participant wear braces (AFOS, SMOS, etc?) Describe how/when to put on and take off.

Can participant walk with assistance or walk independently? Please describe:

PARTICIPANT TRANSFERS:

Please check the amount of staff assistance necessary when conducting a transfer:

- ☐ Independent. No assistance necessary.
- ☐ Stand-by of supervision. May be potential for loss of balance.
- ☐ Transfer with one person. Minimal assistance. Participant can bear weight.
- ☐ Transfer with one person. Maximum assistance. Participant cannot bear weight.
- ☐ Transfer with two people needed.
- ☐ Equipment needed for transfer. (list below)

Specific instructions regarding transfers and how much time participant should be out of the wheelchair?

PARTICIPANT INFORMATION CONTINUED ON NEXT PAGE

PARTICIPANT INFORMATION

TRANSPORTATION NEEDS:

☐ Harness Securement (parent provides vest) ☐ Seatbelt Lock ☐ Oxygen Tank Securement ☐ Bus Aide If yes, Reason_____

☐ Participant drives self ☐ Participant is able to wait independently for transportation Wheelchair straps needed: ☐ Foot straps ☐ Chest straps ☐ Seatbelt

Additional _____

SWIMMING: (check all that apply)

☐ Participant can swim independently

☐ Participant needs assistance while in the pool (list out specific assistance below)

☐ Does not go into pool. (list reason below)

☐ Request one to one staffing in the pool (list reason and describe below)

Describe specific assistance needed in the pool and/or locker room and if pool entry requires transfer assistance from a wheelchair, please describe the process:

TOILETING & CHANGING: (check all that apply)

☐ Needs verbal prompts for toileting/changing (explain below) ☐ Uses pull up/diaper only (specific training required) ☐ Uses toilet independently

☐ Uses toilet, but wears pull up/diapers ☐ Needs physical assistance (specific training required) ☐ Changes independently

Additional/Specific Information: List out frequency of toileting/changing

EATING: (check all that apply)

☐ Eats independently, no assistance needed ☐ Needs physical assistance for feeding (list specifics below) ☐ Can only use specific utensils/equipment

☐ Uses feeding tube (specific training required) ☐ Needs specific consistency for food and drink (list below) ☐ Can only eat what is packed (list allergies or diet plan)

Additional/Specific Information:

BEHAVIOR:

☐ Wander or leaves the group ☐ Has specific triggers, list below ☐ Physically/Verbally aggressive (circle one or both)

☐ Will ask for assistance when needed ☐ Has Behavior Plan ☐ Will take others belongings or food (circle one or both)

☐ Easily distracted/difficulty focusing ☐ Runs away/flight risk ☐ Exhibits self-injurious behaviors, list below

☐ Recognizes danger ☐ Unable to communicate needs ☐ Typical Personality _____

☐ Anxiety when separated from family ☐ Has specific fears/concerns, list below ☐ Other _____

I DO NOT NEED TO UPDATE:

Medication or medical conditions/needs information: ☐

Send us your registration form!

MAIL IN: NWSRA 3000 W. Central Road, Suite 205 Rolling Meadows, IL 60008

FAX: 847/392-2870 Call office to ensure receipt of fax.

E-MAIL: E-mail new fillable registration form to office@nwsra.org

I NEED TO UPDATE:

Medication or medical conditions/needs information: ☐

Complete the following applicable pages.

MEDICATION: In case of an emergency NWSRA is requesting a list of medications participant currently is taking or is prescribed. If medication needs to be administered at program by an NWSRA staff, please sign the waiver and release statement below. Please list all medications below or attach a Physicians order sheet.

Doctor's First Name______________________ **Doctor's Last Name**________________________ **Phone Number** ____________________

NAME OF MEDICATION		NAME OF MEDICATION	
DESCRIPTION		DESCRIPTION	
DOSAGE		DOSAGE	
TIME		TIME	
TAKE AT PROGRAM	☐ YES ☐ NO	TAKE AT PROGRAM	☐ YES ☐ NO
REFRIGERATION NEEDED	☐ YES ☐ NO	REFRIGERATION NEEDED	☐ YES ☐ NO
DISPENSING INSTRUCTIONS		DISPENSING INSTRUCTIONS	
SIDE EFFECTS		SIDE EFFECTS	
NAME OF MEDICATION		NAME OF MEDICATION	
DESCRIPTION		DESCRIPTION	
DOSAGE		DOSAGE	
TIME		TIME	
TAKE AT PROGRAM	☐ YES ☐ NO	TAKE AT PROGRAM	☐ YES ☐ NO
REFRIGERATION NEEDED	☐ YES ☐ NO	REFRIGERATION NEEDED	☐ YES ☐ NO
DISPENSING INSTRUCTIONS		DISPENSING INSTRUCTIONS	
SIDE EFFECTS		SIDE EFFECTS	
NAME OF MEDICATION		NAME OF MEDICATION	
DESCRIPTION		DESCRIPTION	
DOSAGE		DOSAGE	
TIME		TIME	
TAKE AT PROGRAM	☐ YES ☐ NO	TAKE AT PROGRAM	☐ YES ☐ NO
REFRIGERATION NEEDED	☐ YES ☐ NO	REFRIGERATION NEEDED	☐ YES ☐ NO
DISPENSING INSTRUCTIONS		DISPENSING INSTRUCTIONS	
SIDE EFFECTS		SIDE EFFECTS	

ALLERGY/INTOLERANCE (SPECIFY)	REACTION

I, ______________________ give permission for ______________________ to receive the above treatment(s) as directed by the physician. I will provide all supplies needed to provide the treatment. I will notify NWSRA in writing of any changes in the treatment. I understand that an NWSRA staff will assist in the above treatment.

WAIVER AND RELEASE OF ALL CLAIMS

I voluntarily agree to assume the full risk of any and all injuries, damages, or loss, regardless of severity, that the participant may sustain as a result of administered above treatment to the participant. I further agree to waive and relinquish all claims I or the participant may have (or may accrue to the participant) as a result of failing to or negligent administered above treatment to the participant against NWSRA, including it officials, employees, agents and volunteers. I do hereby fully release and forever discharge NWSRA from any and all claims for injuries, damages, or loss the participant may have or which may accrue, and arising out of, connected with, or in any way associated with the dispensing or administration of medication.

SIGNATURE OF PARENT/GUARDIAN: ____________________________________ DATE: __________________

PRINTED NAME OF PARENT/GUARDIAN: ____

MEDICAL INFORMATION

Participant's Full Name:	Date Completed:
Person Completing the Form:	Relationship to Participant:

MEDICAL CONDITIONS/NEEDS:

☐ Seizures ☐ Diabetes ☐ Epi-Pen ☐ G-tube/J-tube ☐ Suctioning (oral/nasal) ☐ Osteotomy bag ☐ Inhaler ☐ Oxygen ☐ Temperature Sensitivity ☐ Shunts

Additional_____

MEDICAL CONDITIONS/NEEDS (CONSIDERED TOO INVASIVE FOR NWSRA STAFF): ☐ Tracheostomy ☐ Suctioning (Deep) ☐ Catheter

***If you checked any of the "too invasive" procedures for NWSRA, a member of the admin team will contact you.**

SEIZURE INFORMATION:

SEIZURE TYPE	DATE DIAGNOSED	LENGTH	FREQUENCY	DESCRIPTION	DATE OF LAST SEIZURE

1. What might trigger a seizure in the participant?_____
2. Are there any warnings and or behavior changes before the seizure occurs? Yes___ No___ If yes, please explain:_____
3. Has there been any recent change in the participant's seizure patterns? Yes___ No___ If yes, please explain:_____
4. How does the participant react after a seizure is over?_____
5. How do other illnesses affect the participant's seizures?_____
6. What first aid/support should be given after a seizure has occurred?_____
7. Please describe what constitutes an emergency for the participant?_____
8. Has the participant ever been hospitalized for continuous seizures? Yes ___ No ___ If yes, please explain:_____
9. What is the best way for us to communicate with you about the participant's seizure(s)_____
10. Is there any other information that NWSRA should know?_____
11. Does your child have a Vagal Nerve Stimulator Yes ___ No ___ If yes, please describe instructions for appropriate magnet use:
12. What medication(s) is the participant prescribed for seizures?

MEDICATION	DATE STARTED	DOSAGE	FREQUENCY AND TIME OF DAY TAKEN	POSSIBLE SIDE EFFECTS

DIABETES INFORMATION:

1. What supplies are needed for participants diabetes care? (testing kit, calorie book, etc.) _____
2. List step by step instructions of testing blood sugar: _____

_____

_____

TESTING FREQUENCY	BASELINE # RANGE	HIGH # RANGE	LOW # RANGE

3. How does participant count/check carbohydrates?_____

EPI-PEN INFORMATION:

1. Where will Epi-Pen be kept?_____

ALLERGY	SEVERITY OF ALLERGY	REACTION

2. List step by step protocol for use of Epi-Pen: _____

_____

3. Check all that apply: ☐ Participant is aware of allergy / knows what foods/items to avoid ☐ Participant is **NOT** aware of allergy / will **NOT** avoid foods/items allergic to
☐ Participant administers own Epi-Pen ☐ NWSRA Staff administers Epi-Pen

G-TUBE/J-TUBE INFORMATION:

1. Type of j/g-tube: ☐ Pump ☐ Bag ☐ Syringe If pump, what rate should it run at?_____

3. What time(s) for feeding? _____

4. Quantity of food: _____ Quantity of water during feeding/throughout the day: _____

5. Is the food and water mixed or does the water follow as a flush? _____

6. Does participant receive feeding sitting up or laying down? _____ Duration of feeding? _____

7. Does participant need to stay upright after feeding? If yes, how long? _____

8. Can participant take solid food or liquids orally or only through g-tube? _____

In the event that the tube comes out, NWSRA considers replacement of any tubes as too invasive for NWSRA staff. If a nurse is available they can use the replacement kit that is provided. If a nurse is unavailable/unable to replace the tubes, the parent/guardian will be called. If the parent/guardian is unreachable EMS will be called.

SUCTION INFORMATION:

1. What type of suctioning is needed? ☐ Nasal ☐ Oral Type of device used? _____

3. Signs/symptoms that suctioning is needed? _____

4. How often does participant need suctioning? _____

5. Specific instructions for suctioning procedure: _____

_____

In the event that deep suctioning is needed, NWSRA considers this procedure as too invasive for NWSRA staff. If a nurse is available they can perform deep suctioning with materials provided. If a nurse is unavailable/unable to perform the deep suctioning, the parent/guardian will be called. If the parent/guardian is unreachable EMS will be called.

OSTOSTOMY BAG:

INHALER INFORMATION:

OXYGEN INFORMATION:

TEMPERATURE SENSITIVITY INFORMATION:

SHUNT INFORMATION:

ADDITIONAL MEDICAL CONDITIONS AND NEEDS THAT NWSRA SHOULD BE AWARE OF:

MEDICAL CONDITION/NEED	ADDITIONAL INFORMATION

I, _____ give permission for _____ to receive the above treatment(s) as directed by the physician. I will provide all supplies needed to provide the treatment. I will notify NWSRA in writing of any changes in the treatment. I understand that an NWSRA staff will assist in the above treatment.

WAIVER AND RELEASE OF ALL CLAIMS

I voluntarily agree to assume the full risk of any and all injuries, damages, or loss, regardless of severity, that the participant may sustain as a result of administered above treatment to the participant. I further agree to waive and relinquish all claims I or the participant may have (or may accrue to the participant) as a result of failing to or negligent administered above treatment to the participant against NWSRA, including it officials, employees, agents and volunteers. I do hereby fully release and forever discharge NWSRA from any and all claims for injuries, damages, or loss the participant may have or which may accrue, and arising out of, connected with, or in any way associated with the dispensing or administration of medication.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

PRINTED NAME OF PARENT/GUARDIAN: _____