Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Camper Application

Please indicate the status of trauma:
____ Primary Trauma (victim of Sexual Abuse)
____ Secondary Trauma (sibling of victim of Sexual Abuse)
If you checked, secondary trauma provide the name of the sibling with
Primay Trauma (First,Last, MI):_____

_____
Initial ATTENTION: Please note that children exposed to secondary trauma must attend with sibiling that meets the criteria for primary trauma.

_____
Initial ATTENTION: Please note that children attending are notified that this is a treatment camp for children exposed to Primary and Secondary Trauma of Sexual Abuse

Has the camper been to camp before? _____ Yes _____ No
If yes, how many years has camper attended? _____
Has camper attended counseling before? _____ Yes _____ No
If yes, when, where, and how long ? _____

_____ ATTENTION: Please note that the information contained in this document is CONFIDENTIAL. Emailing this form may be a breach of HIPAA. Family Counseling Service takes no responsibility for actions by others that result in HIPAA violation.
Initials

Camper's Name: _____ Age: _____ Date of Birth: _____
Last First

Gender (Check One) ☐ Male ☐ Female Age at Camp: _____ Ethnicity: _____ Adult Shirt Size _____

Home Address of Child _____
Street Address City State Zip

Legal Guardian: _____
Last First

Address: _____
Street City State Zip

Contact Number_____ Email Address: _____

If camper lives with ***someone other than legal guardian*** this information is required:

Name of person camper lives with _____ Phone: _(_____)_____
Last First

Address: _____
Street Address City State Zip

Emergency Contact (person legally responsible for camper):

Name: _____ Relationship to camper: _____

Daytime Phone Number: (_____)_____ Evening Phone Number: (_____)_____

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Address: _____ _____ _____
Street Address City State Zip

Camper's Name: _____ Birth Date: _____

Insurance Information (Must Be Completed)

Does camper have medical insurance? (Please Check One)

☐ Yes ☐ No

Insurance carrier or plan name: _____ Group Number: _____

Name of insured: _____ Relationship to camper: _____

Insurance ID number: _____

Dietary/Allergies

Any dietary restrictions? ex: lactose intolerant

_____

Medication Allergies: _____

_____

Other Allergies: ex: seasonal, animal dander, bug bites/stings etc. _____

_____

Restrictions

Explain any restrictions to physical activity or special needs: _____

_____

Explain any other known restrictions while at camp: _____

_____

_____

Additional information for health care staff at the camp: _____

_____

Please use this space to provide any additional information about the camper's behavioral and physical, emotional, or mental health needs which the camp staff should be aware. **This information is important to ensure that your camper receives appropriate care**.

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Treatment Summer of Healing Camp Application

Camper's Name: _____ Birth Date: _____

Please have the camper explain in his or her own words why s/he wants to attend camp (we may be conducting phone interviews as well):

Please provide a brief statement concerning the child's sexual abuse, age when it happened, perpetrator relationship to the child, was the incident reported, and what was the judgeent of the case? (we may be conducting phone interviews as well):

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Camper's Name: _____ Birth Date: _____

Camper Medical History

Please indicate if the camper has ever experienced any of the following:

	Yes	No		Yes	No
Severe/Frequent Headaches			Asthma		
Head Injury/Knocked Unconscious			Shortness Of Breath		
Fainting Spells			Frequent Diarrhea/Constipation		
Hospitalization			Frequent Nausea/Vomiting		
Seizures/Convulsions			Prolonged High Fever		
Glasses/Contacts			Bedwetting		
Dizzy/Pain After Exercise			Soiling Pants		
Hearing Impairment/Ear Trouble			Difficulty Speaking		
Heart Disease/Murmurs			Difficulty Sleeping/Sleep Walking		
Difficulty Eating/Eating Disorders			Abrupt Weight Gain Or Loss		
Food Allergies			Skin Problems (Rash, Acne, Itching)		
Birth Defects			Kidney Or Urinary Disease		
Blood Disease/High Blood Pressure			Developmental Delays		
Bone Or Joint Problems			Muscle Disease		
Lung Disease			Nerve Disease		
Diabetes			Rheumatic Fever		
Glandular Disease			Tuberculosis		
Venereal Disease			Jaundice Or Hepatitis		
Learning Disability			Coordination Difficulties		
Chronic Or Recurring Illness			Surgeries		
Back Problem			Orthodontic Appliance At Camp		
Lice, scabies or bed bugs, in the past 12 months			Emotional Difficulties For Which Professional Help Was Sought		
Recent Injury, Illness Or Infectious Diseases Within Past 12 Months			Camper was exposed to sexual abuse, sexual violence or sexual exploitation		

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Camper's Name: _____ Birth Date: _____

Camper Behavior History

Please indicate all that apply:

	Yes	No		Yes	No
Currently on Probation/ Parole			On Probation/ Parole House arrest in past		
Currently on House Arrest/ Curfew			History of Drug Use		
History of violence			History of Alcohol Use		
History of arrest			History of Self Harming		
Been in Residential Treatment Center					
Been hospitalized for Mental Health					
History of running away					

If any of the boxes were answered "YES" please explain below with as much detail as possible, including age of occurrence/s.

_____

_____

_____

_____

_____

_____

Please provide information regarding camper's exposure to domestic violence, sexual abuse, physical abuse or neglect. Provide as much information as you can, including perpetrator, what type of abuse was experienced/witnessed, when and where abuse occurred, and when/how family left the situation. ***Please indicate when this was reported to law enforcement, and if there is a pending court date***. This helps us to understand more about your camper's specific situation and insure proper authorities have been contacted.

_____

_____

_____

_____

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Camper's Name: _____ Birth Date: _____

Important-This Box Must be Complete for Attendance to Camp

Parent/Guardian Authorization: Attached health history is correct and complete to the best of my knowledge. The person described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named herein.

Signature of parent/guardian: _____

Printed Name: _____ Date: _____

Additional Documents to be Signed and Turned in with Camp Application

- ☐ Transportation Release Form
- ☐ Consent for Medical Treatment
- ☐ Physician's Information form
- ☐ Physician's Order Form (If your child will be taking medication while at camp)
- ☐ Application for Service and General Consent to Treat (**only turn in third page**)
- ☐ Waiver and Release of Liability

Note: Camp Application **will not** be processed until all forms and documentation have been turned in.

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Application for Service and General Consent

Client's Rights and Responsibilities

The client and the provider have a responsibility to each other to assure that the best possible service is provided and appropriately used.

Each client has the right to the following:

- Considerate and respectful service.
- Service provided by qualified personnel.
- A reasonable response to his/her request for service and reasonable continuity of care.
- To lodge a complaint, verbally or in writing, when he/she feels any of their rights to service have been violated by a representative of the agency. The executive director will return a decision to you within 14 days of receiving your complaint. You may appeal the decision, verbally or in writing, to the Family Counseling Service Board of Trustees. The receptionist will provide you the phone number and address of the current board president. The board of trustees will return a decision to you within 14 days of receiving your appeal. Forms are available from any staff member.
- Freedom from retribution or other adverse consequences as a result of filing a grievance.
- Service without discrimination as to race, religion, age, marital status, gender, national or ethnic origin, or sexual orientation.
- To participate in development of his/her treatment plan.
- To accept or reject any treatment plan.
- Family Counseling Service (FCS) policies, such as eligibility for service, regulations and hours of service, and fee information.
- Assistance in locating the appropriate service when continuity of care can not be provided by FCS.
- To examine and receive an explanation of his/her bill for service, regardless of the payment source.
- To receive a Copy of the Client's Rights and Responsibilities at the time service begins.
- To be informed of the name, date, title and professional credentials of any person providing his/her service.
- To review their case record in accordance with FCS policy.

Each Client has the Responsibility to:

- Accept or refuse service.
- Direct grievances, concerns and recommendations for change, verbally or in writing to your therapist, the executive director, or other FCS staff. Grievance or complaint forms are available from the reception area staff, your counselor, or any FCS employee.
- Keep all scheduled appointments or give a 24-hour notice of cancellation. FCS reserves the right to refuse to schedule appointments for those who have not appeared for two or more appointments. FCS will charge clients a full fee for appointments where less than 24 hours' notice is not given.

Family Counseling Service of Northern Nevada
Treatment Summer of Healing Camp Application

Client Confidentiality

The clinical staff of FCS are required by law, professional ethics and standard agency practice to maintain client confidentiality. The confidentiality of client records maintained by this program is protected by federal law (42 USC 290 dd-3 and 42 USC 290ee-30) and federal regulation (42 CFR Part 2). **Generally**, the agency may not say to a person outside the agency that a client attends counseling or treatment at the agency, or may not disclose any information identifying the client as a client **unless:**

- The client consents in writing, or
- The disclosure is allowed by court order, or
- The disclosure is made to medical personnel in a medical emergency, or to a qualified person for research, audit or program evaluation, or
- The client commits or threatens to commit a crime either at the agency or against any person who works for the agency

and, if a client threatens suicide or grave bodily harm to another person, we may choose to notify the appropriate law enforcement agencies and/or the intended victim. *Whenever there is a reason to believe that a child or elderly person is subject to abuse, we are required by law to inform appropriate law enforcement and/or welfare agencies.*

and, if a court of law issues a legitimate subpoena, we are required by law to provide the information specifically described in the subpoena. If a client is in therapy or being tested by order of a court of law, the results of the treatment or tests ordered may be revealed to the court by consent of the client.

APPENDIX F

WAIVER AND RELEASE OF LIABILITY
(Camper/staff/volunteer – Minor)

Release and waiver of liability and indemnity agreement. I further agree to indemnify, protect, defend, and hold harmless Camp Ronald McDonald at Eagle Lake, Ronal McDonald House Charities Northern California and their directors, officers, employees, volunteers, and/or agents from and against any cost, damage, expense, claim, or liabilitycaused by or arising out of my use of, presence at, or trip to or from the facilities of Camp Ronald McDonald at Eagle Lake, including any injury to or death of any person, any damageto any real or personal property on or about the Camp or belonging to Camp Ronald McDonald or Ronald McDonald House Charities Northern California and any attorney's fees and/or costs arising out of this Agreement.

I, the undersigned, hereby waive any and all claims that I or my heirs may have against the directors, officers, employees, volunteers, and/or agents of Camp Ronald McDonald at Eagle Lake or Ronald McDonald House Charities Northern California for any injuries or property damages which may arise while my child is on the Camp Ronald McDonald premises. I acknowledge that this waiver includes any claim for wrongful death, personal injury or property damage caused by or rising out of the negligence of Camp Ronald McDonald at Eagle Lake, Ronald McDonald House Charities Northern California, or their directors, officers, employees, volunteers and/or agents.

Authorization for use of photo. I hereby authorize authorize Camp Ronald McDonald at Eagle Lake and Ronald McDonald House Charities Northern California to use, for any purpose whatsoever, any photograph (including digital media and videotape) taken at or near Camp Ronald McDonald at Eagle Lake that contains my child's likeness.

Date: _____

Signature of Parent/Guardian: _____

Printed Name: _____

Minor's Name: _____

Camp Session _____

Family Counseling Service of Northern Nevada
Camper Application

Consent for Medical Treatment

All information requested on this form must be completed

As the parent, legal guardian or agency representative, I hereby give consent to Family Counseling Services of Northern Nevada to provide all emergency medical or dental care prescribed by a duly licensed medical doctor or dentist for:

Name of Child: _____

This care may be given under whatever conditions necessary to preserve the life, limb or well-being of the child named above.

Parent/Guardian or Agency Representative: _____
Printed Name

Signature: _____

Date: _____

Address of signer: _____
Street Address City State Zip

Daytime Contact Phone: _____

Evening Contact Phone: _____

Rev: 1/2020

Family Counseling Service of Northern Nevada
Camper Application

Physician's Information

Name of child's physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Name of child's dentist/orthodontist: _____ Phone: _____

Address: _____ City: _____ State: _____

Medications Being Taken

Please list **ALL** medications that will be taken while at camp, including any over-the-counter or non-prescription drugs. **Bring enough medication to last the entire time at camp (7 days, 6 nights)**. Keep it in its original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Place all medications, a photo of the camper, and the physician's order in a plastic zip-lock bag with the camper's name written on the outside. **If your camper will be taking medications while at camp, a physician's order MUST be turned in, otherwise we will not be able to administer their medication. Medication listed here must match the Physician's Order.**

☐ This person takes NO medication on a routine basis.

☐ This person takes medication as follows:

Med #1: _____ Dosage: _____ Specific times taken each day

Reason for taking: _____

Med #2: _____ Dosage: _____ Specific times taken each day

Reason for taking: _____

Med #3: _____ Dosage: _____ Specific times taken each day

Reason for taking: _____

Med #4: _____ Dosage: _____ Specific times taken each day

Reason for taking: _____

Attach additional pages for more medications. Turn in completed Physician's Order with this packet.

Family Counseling Service of Northern Nevada
Camper Application

Physician's Order

Date: _____

To Whom It May Concern:

The child listed below will be attending the Safe Families Summer Treatment Camp sponsored by Family Counseling Service at Camp Ronald McDonald located at Eagle Lake, California. The person who completed the application for this child indicated that he/she is taking medication. In order to ensure that all medication is taken as prescribed while this child is at camp, please complete the Physician's Order form below. Please indicate the name of the medication, the dosage and frequency. Please include over-the-counter as well as prescription medications.

Name of Child: _____

Parent/Guardian's Name: _____

Physician's Name: _____

Practice Name: _____

Practice Address: _____

Office Phone Number: _____

Medication	Dose	Administration Information

Physician's Signature: _____ Date: _____

DEA#: _____

Rev: 1/2020

Family Counseling Service of Northern Nevada
Camper Application

Transportation Release Form

I hereby give my permission to have my child transported to and from the Safe Families Summer Treatment Camp located at Camp Ronald McDonald at Eagle Lake, California. I give permission to have my child transported by staff, volunteer counselors, or other professionals associated with the camp. I release any person providing such transportation for my child from any personal liability.

Name of Child: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____