**Family Counseling Service of Northern Nevada**
**SAFE FAMILIES Treatment Camp**

# Camper Application

Has camper come to camp before? Yes or No
If yes, how many years has camper come to camp? ____

ATTENTION PROFESSIONALS: Please note that this document contains confidential information. Emailing this form may be in breach of HIPAA. Family Counseling Service takes no responsibility for the consequences should your actions result in violation of HIPAA compliance.

Camper's Name: ______________________________________________ Age: ____ Birth Date: ___________
Last First Middle

Gender (Please Check One): ☐ Male ☐ Female Ethnicity: ______________ Adult Shirt Size: ______

Is the child in custody of: the state, 2 parents, 1 parent, split custody, or adoptive parents

Home Address of Child: ________________________________________________________________
Street Address City State Zip

Legal Guardian: ______________________________________________________________________
Last First

Address: ___________________________________________________________________________
Street Address 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: ______________
Last First

Daytime Phone Number: _(____)_________________ Evening Phone Number: _( ___)_____________

Address: ___________________________________________________________________________
Street Address City State Zip

Does the camper have the ability to participate in structured activities throughout the day without one-on-one supervision, guidance and minimal re-direction? Please describe:

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## 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.

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## Restrictions

Explain any restriction 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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## 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 | | | Current Orthodontic Appliance | | |
| Lice, Scabies Or Bed Bugs, In The Past 12 Months | | | Sought Professional Help For Emotional Difficulties | | |
| Recent Injury, Illness Or Infectious Diseases Within Past 12 Months | | | | | |

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## Camper Medical History

Camper's Name: ________________________________________ Birth Date: ______________

If any of the boxes on the previous page were answered "YES" please explain below. If you marked surgery or hospitalization on previous page, state age of occurrence.

Please provide information regarding your camper's exposure to violence. (in the home or other) Provide as much information as you can, including perpetrator, what type of violence was experienced/ witnessed, when and where it occurred, and when family left the violent situation. ***Please provide 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 ensure proper authorities have been contacted.

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**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 FCS 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 FCS 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 FCS 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
- ☐ Waiver and Release of Liability

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

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# 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 cannot 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.

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**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.

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# Transportation Release Form

I hereby give my permission to have my child transported to and from the Safe Families 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: ____________________

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# 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: ______________________________

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# 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 to be taken at camp. Include any over-the-counter drugs. **Bring enough medication to last (7 days, 6 nights)**. Medications must be in original packaging that identifies the prescribing physician, 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.

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# Physician's Order

Date: ____________

To Whom It May Concern:

The child listed below will be attending the Safe Families 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#: _______________

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# Waiver and Release of Liability

To be signed by Parents/Guardians, Staff and Volunteers

**Release and waiver of liability and indemnity agreement.** I further agree to indemnify, protect, defend and hold harmless Camp Ronald McDonald at Eagle Lake, Ronald McDonald House Charities Northern California and their directors, officers, employees, volunteers, and/or agents from and against any cost, damage, expense, claim, or liability caused 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 damage to 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**. Adult participants 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.

Date: ___________________

Signature of Parent/Guardian, Paid Staff or Volunteer

_____________________________________________

Printed Name: ________________________________

Minor's Name: ________________________________