

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

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					

**Family Counseling Service of Northern Nevada
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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 sexual abuse. Provide as much information as you can, including perpetrator, what type of abuse, when and where abuse occurred, and when /if family left the 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.

**Family Counseling Service of Northern Nevada
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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.

**Family Counseling Service of Northern Nevada
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Transportation Release Form

I hereby give my permission to have my child transported to and from the Summer of Healing Treatment Summer 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: _____

**Family Counseling Service of Northern Nevada
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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: _____

**Family Counseling Service of Northern Nevada
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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 Summer of Healing 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#: _____

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

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 arising 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: _____