



**OPPORTUNITIES UNLIMITED
CAMP HAPPINESS PROGRAM APPLICATION**

Consumer Name _____ **D.O.B.** _____

Parent / Family Member Name _____

Address _____ **Home Phone #** _____

Cell Phone # _____ **Work Phone #** _____, **ext.** _____

SS # _____ **Gender:** Male _____ Female _____

Medicaid # _____ **Allergies** _____

Other Health Insurance: Please list Carrier and group #: _____

**** A photocopy of front and back of health insurance card must be attached to this form**

Adapted Devices: Please list (ex.: Wears eyeglasses, utilizes walker, hearing aid, etc.):

Emergency Contact Person (someone outside of the residence where they live):

Name _____ **Relationship** _____

Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

Medicaid Service Coordinator / Case Manager (if applicable):

Name _____ **Agency** _____

Phone # _____ **Cell phone #** _____

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Medical Status:

List chronic health concerns (allergies, cardiac difficulties, asthma, any physical restrictions, seizures, avoid excessive sun exposure. Please include approximate date of last seizure.

Prescription Medications:

Medication	<u>Form:</u> Pill / Capsule, Suspension (liquid), Topical / Cream	Times Taken	Taken With Food / Drink	Dosage

Level of Assistance: Please check the appropriate box

Skill Area	Independent	Reminders Required	Moderate Assistance	Maximum Assistance
Dressing				
Bathing/showering				
Ordering				
Hygiene				
Feeding				

Physical Restrictions for Activities (please be specific): _____

Can he / she Tolerate Water Swimming (any allergies to chlorine): _____

Specific Fears / Dislikes (i.e., heights, amusement park rides (list specifics), large crowds, dogs):

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Dietary restrictions (please be specific) : _____

Favorite Foods: _____

Tee Shirt Size (circle one): Medium Large XLarge XXLarge

Parent/Guardian Authorizations:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted above.

I hereby give permission to Opportunities Unlimited and Camp Happiness staff (Lockport YMCA) to give first aid, administer prescription medications (nurse will be present), and seek emergency medical treatment including ordering x rays or routine test (if necessary). I agree to the release of any records necessary for insurance purposes.

I give Opportunities Unlimited and Lockport YMCA permission to arrange necessary related transportation for my child. In the event I can't 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 above.

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

HIPAA Authorization

I am specifically granting permission to all parties affiliated with Camp Happiness, and anyone authorized by Camp Happiness, to use _____ (print name of participant) likeness, voice, and words in photographs, television, radio, films, video, newspapers, magazines, reports, website, and other media, and in any other form not heretofore described for the purpose of advertising or communicating the purposes and activities of Camp Happiness and its affiliates, and in appealing for funds to support such activities without further compensation to he / she. All originals, negatives, and prints shall constitute, solely and completely, the property of Camp Happiness or their authorized agents. I understand that I have the option of revoking this consent at any time through notification to the Community Relations Department of Opportunities Unlimited of Niagara. This consent only expires upon revocation of this form.

Signature of Parent / Guardian: _____ Date: _____

Printed Name: _____

Signature of Camp Participant / Date: _____