



Brain Injury Adventure Camp of Kentucky

TBI CAMPER APPLICATION

Return Application to:
 BIAC
 P.O. Box 236
 Robards, KY 42452

**Please mail camp fee of \$325 with application.
 Make checks payable to BIAC
 TBI Buddy can attend at no charge
 Buddy must complete an application also.**

For Office Use Only:
 Application Received: _____ DATE Payment Received: _____ DATE Amount: _____
 Acceptance Letter Sent Date: _____
 Buddy Name: _____ Phone: _____

Camper

Name: _____
 Address: _____ Age: _____ Male: _____ Female: _____
 City: _____ Height: _____ Weight: _____
 State: _____ Zip: _____ Birthdate: _____
 Phone: Cell _____ Home _____ Will a buddy/helper be attending with you? _____
 Email: _____ If yes, Buddy Name _____

Guardian

Name: _____ Relationship to Camper:
 Address: _____ ___ Spouse ___ Parent ___ Case Manager
 City: _____ ___ Sibling ___ Other (please specify)
 State: _____ Zip: _____
 Phone: Cell _____ Home _____ Work _____
 Email: _____

Emergency Contacts

Please be sure these people will be available during the week of camp.

Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Phone: Cell _____ Home _____
 Email: _____

Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Phone: Cell _____ Home _____
 Email: _____

Do you have a Medical Power of Attorney? ___ Yes ___ No If yes, Person _____ Phone _____
 Current Physician: _____ Phone _____
 Medical Insurance: ___ Yes ___ No Name of Insurance Company: _____
 Policy Number: _____ Policy Holder: _____

Do you receive email updates from BIAC? Yes ___ No ___

Please circle and/or fill-in blanks:

Mobility: Walks independently Manual wheelchair Electric wheelchair Walker Cane Crutches Other: _____

If in a wheelchair:

Do you use the chair? All the time Just when fatigued Just outside Not at home, just camp Not at camp

Do you operate the wheelchair independently? ___Yes ___No Explain: _____

Transfers: ___No assist ___Total Assist ___Pivot with spotter ___Other: _____

Weight shifts: ___None ___Yes, required How often? _____ Assistance: _____ Props

Do you have balance concerns? ___No ___Yes Explain _____

Do you have walking concerns? ___No ___Yes Explain _____

Do you require assistance on rough, uneven terrain ? ___No ___Yes Explain: _____

How far can you walk? with assistance _____ without assistance _____

Can you walk up and down stairs independently? ___No ___Yes Explain _____

Other adaptive devices:

None Nightbraces/AFO's Prosthesis Helmet Glasses/Contacts Hearing Aid Dentures

Other: _____

Seizures: ___Yes ___No Type: _____

Date of last on: _____ Are they controlled by Medication? ___Yes ___No Meds used: _____

Can you tell if a seizure is coming on? ___Yes ___No How? _____

Speech Concerns: Normal Mildly affected Moderately affected Severely affected Few words Non-verbal

Communication:

Speaks Uses sign language Uses Communication Board Uses device Gestures

Other _____

Can you understand what is said to you ? ___Yes ___No Explain _____

Can you express your needs? ___Yes ___No Explain _____

Do you know sign language? (But may not use it daily) ___Yes ___No

Hearing: Normal Hard of hearing Wears hearing aid sensitive to "excessive noise" Extremely sensitive

Vision: Normal Legally blind Total loss No peripheral vision Wears glasses Contacts Other: _____

Are you in the habit of wearing sunglasses? ___Yes ___No (Please bring sunglasses with you with a retention cord)

Vitals: Any heart problems? ___Y ___N Heart murmur? ___Y ___N Irregular heart beat? ___Y ___N Blood pressure concerns ___Y ___N

Behavior:

How is your memory? It's O.K. Mild short-term memory loss Severe short term memory loss

Extreme STM loss - Explain _____

In a new situation do you? Get lost Lose belongings Run away Wander off

Do you have anger Issues? None Mild Sometimes Severe Often Cause? _____

What helps to calm you down? _____

Do you get frustrated? Never Sometimes Occasionally Often Always Cause? _____

Do you get depressed? Never Sometimes Occasionally Often Always Controlled by meds? _____

Do you get paranoid? Never Sometimes Occasionally Often Always Controlled by meds? _____

What are your fears? _____

Do you ever lose verbal control? (scream and shout)? ___Yes ___No Do you ever lose physical control (hit, etc.)? ___Yes ___No

Are you currently receiving Psychotherapy? ___Yes ___No Dr. _____ Phone _____

Personal Hygiene

For women: Do you need assistance with feminine products: ___Yes ___No Uses? Pads Tampons

Do you smoke? ___Yes ___No How much? _____

Toileting:

Toilet needs: No assist Partial assist Total assist

Bladder needs: None Incontinent Needs reminders Needs to go very often Explain _____

Bowel needs: None Incontinent Needs reminders Constant diarrhea Explain: _____

Please list toileting schedule _____

Describe behavior related to disrupted toilet habits _____

How long does bowel routine normally take? _____

Aids used:

None Urinal P.M. urinal Catheter P.M. Catheter Toilet chair Diapers

P.M. Diapers Ostomy bag Bedpan Suppositories - when? _____ Enema - When? _____

Other _____

What are you doing when you are not at camp?

Where do you live?

Own home With family Apartment alone Group home Apartment with roommate Assisted Living Facility

Are you currently involved in a day program? Yes No Where _____

Are you in school? Yes No Grade: _____ School _____

How do you get around? Walk Bike Drive Bus Special transit Arranged rides Wheelchair

Some fun questions!

Do you sing: Yes No Do you play an instrument? Yes No Instrument _____

Jokes? I like to hear them I like to tell them Stories? I like to hear them I like to tell them

Your favorite activities/hobbies:

Inside: _____

Outside: _____

Who is your HERO? _____ Why? _____

Camp questions: T-shirt size: S M L XL XXL

List other camps that you have attended: _____

Do you have special goals for camp this year? _____

Please provide two (2) character references: NAME, RELATIONSHIP, PHONE, EMAIL
(Required information for acceptance)

Name	Relationship	Phone	Email

Agreement, Consent and Release

With the understanding that the Brain Injury Adventure Camp, Inc. (BIAC) will make every reasonable effort to prevent accidents, injuries and/or other mishaps, I acknowledge the following:

The undersigned give the Brain Injury Adventure Camp, Inc. (BIAC) permission to verify any information on this application and to contact references, case managers, and emergency contacts for any further information, which may be necessary.

The undersigned agrees to indemnify and hold harmless the BIAC for any and all claims, demands, costs, expenses, including reasonable attorney's fees, that the BIAC may incur as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the BIAC from any act of negligence or fault on the part of the BIAC, its officers, agents or employees.

The undersigned does consent that photographs or video pictures may be taken of the named applicant during the camp period, and that said photographs and video may be published in newspapers, magazines, television, publicity releases and/or other media.

The undersigned, in case of an emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery and other procedures, etc.

The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted).

The undersigned gives permission for the applicant to ride in vehicles operated or leased by the BIAC.

The undersigned recognizes the right of the Camp Director or the BIAC Lead, in his/her discretion, to terminate a camper or volunteer's stay at any time due to disciplinary or medical actions which might jeopardize their own health or safety, or other's health and safety at camp. The undersigned further agrees to pick up the camper or volunteer immediately upon being notified of such termination.

The undersigned agrees not to send the applicant (to attend or volunteer), one of the BIAC programs if he/she has been exposed to a contagious disease within three (3) weeks of the start of camp, and to notify the BIAC is such a case should arise.

If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned. I do hereby authorize (name, address, phone) _____
_____ to pick up the camper or volunteer.

Please list anyone you DO NOT want to pick up camper/
volunteer _____

Today's Date: _____ when this Agreement, Consent and Release has been read and signed.

Applicant's Signature: _____ Printed _____

Legal Guardian Signature _____ Name _____