CAMP BRUCE McCOY
HELP, HOPE, & HEALING
BRAIN INJURY ASSOCIATION OF VIRGINIA

2019 PROGRAM APPLICATION
PROGRAM DETAILS

WHEN: Week 1: Sunday, May 19th - Saturday, May 25th
Week 2: Sunday, May 26th - Saturday, June 1st

WHERE: Triple-R Ranch in Chesapeake, Virginia

APPLICATION DEADLINE: April 15, 2019 or until all spots are filled. Apply early! Campers may apply for only one week. If you are interested in attending both weeks and the weekend mini-camp, please indicate this by marking the designated box. Campers eligible for consideration for two weeks will be based on date of receipt at BIAV of ***all parts*** of a fully completed application, level of care required, and other pertinent medical or behavioral needs; final decisions will be made at the discretion of the Medical Advisor and Camp Manager.

CAMP FEES: $535.00 per week; ($85 for weekend mini-camp). Please do NOT submit payment until you have been notified about your acceptance. We will provide an invoice along with notification about your acceptance. If a camper decides not to attend, a full refund will be issued if BIAV is notified at least two weeks prior to the beginning of that session. After that date, a $50 cancellation fee will be charged. If the camper is unable to attend due to illness or family emergency, a full refund will be issued.

FINANCIAL ASSISTANCE: If financial assistance is required, please complete a scholarship application. **Do not delay submitting the application because of financial need**; your space at camp can be reserved while support is being sought. BIAV will provide information on local sources of support that may be able to provide scholarship assistance. Based upon availability of funds, full scholarships may be available to ***new*** campers only; partial scholarships up to $267.50 may be available to returning campers.

ATTENDANTS: If a personal care attendant is required, BIAV will hire qualified individuals to perform those functions; the cost is an additional $275. A camper's personal paid attendant may be able to attend camp and provide the required assistance; final decisions will be made at the discretion of the Medical Advisor and Camp Manager. The cost of lodging and meals for an attendant while at camp will be paid by BIAV.

CAMP BRUCE McCOY 2019
CAMPER APPLICATION

I am interested in attending: **(YOU MUST CHECK ONLY ONE OF THESE)**

☐ Week 1 (May 19 - 25)

☐ Week 2 (May 26 – June 1)

☐ Both weeks and the weekend mini-camp (**if** spots are available)

Name:_____
(Last) (First) (Nickname)

Age:_____Date of Birth:_____Sex:_____SSN:_____

Height:_____ Weight:_____ T-Shirt Size:_____

Address:_____
(Street) (City) (State) (Zip)

Telephone:
(Day)_____ (Evening)_____

E-Mail address: _____

Parent or Guardian Name & Relationship to Camper:
_____

Is address same? Yes ☐ No ☐ If no, please complete the following:

Address:
_____
(Street) (City) (State) (Zip)

Telephone: (Home)_____ (Cell)_____

If family will not be at this address during camp please provide telephone number where family can be reached in case of an emergency:

Telephone: (Home)_____ (Cell) _____

If there is no family contact, please provide name, address and telephone number for person to contact in case of an emergency:

Name: _____Relationship:_____

Address:_____
(Street) (City) (State) (Zip)

Telephone: (Home)_____ (Cell)_____

Name of camper's Case Manager (if one) and their contact information:

_____

If the applicant has previously attended camp, has his or her overall level of function changed since then? Yes☐ No☐ If yes, please explain:

_____

The following information must be entirely filled out to qualify as a fully completed application

LEVEL OF FUNCTION

- Length of time since injury:_____months/years
- Details on the type of brain injury; general description of recovery and post-injury history.

_____

_____

_____

_____

- Is the applicant currently enrolled in a rehabilitation or day program? If yes, where?

_____

- Are there any special precautions the applicant needs that camp staff need to know (swallowing, diabetes, asthma, difficulty with medicines)?

_____

- Are there particular habits or concerns of which camp staff should be aware (food dislikes, sleeping patterns, wandering, inappropriate language or behavior)?

_____

- Has the applicant ever been charged with a misdemeanor or felony? Yes☐ No☐ If yes, please explain and state the outcome.

_____

- Please indicate applicant's problem areas:
  Paralysis☐ Short term memory☐ Vision☐ Hearing☐
  Agitation☐ Attention span☐ Behavioral☐ Speech☐
- Does applicant use: Cane☐ Leg braces☐ Walker☐ Wheelchair☐
  If applicant uses wheelchair, is it manual or power? _____
  Can applicant propel indoors? ☐ Outdoors?☐ What, if any, assistance is needed?

_____

- Is applicant able to transfer him/herself from chair (to bed, bath or toilet)? _____
  If no, what assistance is required?_____

Please indicate the level and type of assistance the applicant requires for each of the following, as well as any equipment that is needed or used at home.

Dressing/Undressing:
Level of assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Type of assistance:_____

Eating:
Level of assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Needs intake monitored ☐ Chokes ☐ Equipment used_____

Toileting:
Level of Assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Continent of bladder? ☐ Bowel? ☐ Uses Urinal ☐ Requires diapers ☐

Bathing & Hygiene:
Level of Assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Needs reminding ☐ Equipment used_____

Walking:
Indoors:
Level of Assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Outdoors:
Level of Assistance None ☐ Minimal ☐ Moderate ☐ Total ☐
Distance applicant able to walk at a time:_____
Equipment used_____

Please address the following if applicable; provide details and strategies that may be helpful.

Cognitive issues:_____

_____

Physical limitations:_____

_____

Emotional/Behavioral issues:_____

_____

Communication issues: Is the applicant's speech understandable?_____If no, how does the applicant make his/her needs and wants known?

_____

MEDICAL

- Has the applicant been immunized for Tetanus? Yes ☐ No ☐ Last booster_____
- Does the applicant have Advanced Directives?_____If yes, please provide a copy.
- Does the applicant have a DNR status? Yes ☐ No ☐ If yes, please provide a copy.
- Does the applicant have skin breakdown problems? _____If yes, please provide details.

- Has applicant visited a hospital or physician for anything other than therapy or routine medical appointments in past twelve (12) months? _____If yes, what?_____

- Has applicant had seizures? _____If yes, when was last one? _____
- If seizures have occurred, indicate frequency and type of seizures; also indicate any "auras" or pre-seizure behaviors that have occurred and applicant's behavior after seizure has ended.

- Any known allergies (i.e. medication, food, environmental, etc.)? Yes ☐ No ☐ If yes, state allergy, nature of reaction and treatment:

- Is the applicant able to manage his/her medications at home? Yes ☐ No ☐
  With help ☐ Type of assistance needed_____

Please indicate any non-prescription medication applicant regularly uses:

Should family be notified if seizure occurs, or non-emergency medical treatment is required (for example, a sprained ankle or minor injury)? Yes ☐ No ☐

Primary Care Physician Information:

Name:_____

Address:_____

Telephone: _____Emergency#:_____

The date of the applicant's last visit with his/her Primary Care Physician: _____

A medical letter of clearance and current list of medication must be signed by the applicant's primary care physician, and a release of medical information form must be signed by camper or guardian.

BOTH FORMS ARE REQUIRED AND MUST BE RECEIVED NO LATER THAN FRIDAY MAY 17, 2019 TO ENSURE PARTICIPATION IN THE PROGRAM

*Please list other physicians to be contacted if a medical condition arises during camp:

Name	Specialty	Telephone #

INSURANCE:

Insurer: _____Policy #:_____

(Provide copy of insurance and Medicare/Medicaid cards with application)

ALL THREE OF THE FOLLOWING PARTS MUST BE COMPLETED!

In the event I cannot be reached in an emergency, I hereby give permission to the camp Medical Director, Dr. Nathan Zasler, or a physician so designated by him to evaluate and/or treat (including ordering any medically necessary measures such as imaging studies, medications, anesthesia or surgery). I understand that Dr. Zasler's services are provided at no cost as he volunteers as the camp Medical Director; however, in an emergency situation, other providers will be billing for their services. In a situation where I cannot be reached and Dr. Zasler must make emergency medical decisions, I agree to hold him harmless of any damages unless there is gross negligence on his part as the camp Medical Director.

By way of this consent, I also give permission for any of the aforementioned clinicians to access information on _____ from his/her treating physician(s). My signature below acknowledges my understanding of the above and agreement to same.

_____

Signature of parent/guardian or camper Date

_____

Signature of Witness Date

****

I hereby acknowledge that I am fully aware of the risks involved in participating in the activities at Camp Bruce McCoy and have taken into account the disability and/or impairments of _____ _____with respect to making the decision to participate in the program. I hereby release the Brain Injury Association of Virginia, its employees and agents from any and all claims arising from Camp McCoy.

_____

Signature of parent/guardian or camper Date

_____

Signature of Witness Date

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At various times during the camp program, print and television media will be invited to camp. In addition, BIAV may develop video or photographic displays about camp.
I do ☐ do not ☐ give permission for _____ to be filmed or interviewed for public purposes.

_____

Signature of parent/guardian or camper Date

_____

Signature of Witness Date