It's Camp Bloomfield time!

Thank you for your interest in **Camp Bloomfield's Adult Camp!** We're very excited to have you join us this summer.

During Adult Camp, you will have the opportunity to participate in sports, music and traditional camp activities such as archery, arts and crafts, swimming, the climbing wall, ropes course, horseback riding and much more!

The attached Adult Camp Application packet applies to adults, ages 18 years or older, who are blind or visually impaired and sighted aides accompanying campers to Adult Camp (if needed). If participants plan to attend multiple sessions (for example, Adult Camp and Family Camp), one application can be used for all sessions, per applicant.

Please complete the packet entirely and return it to Wayfinder Family Services **as soon as possible** along with a **$25 registration fee** (per adult, check or money order made payable to Wayfinder Family Services), a **2" x 2" portrait photo** (mandatory) and a **copy of the participant's medical insurance or Medi-Cal card** to tentatively hold a space in the session.

Please note that the Health History Questionnaire (Form 2) and the Self-Disclosed Immunization History (Form 3) **must be completed by each camper every summer, regardless of their prior attendance at Camp Bloomfield.** These forms should be completed by the adult camper and do not require a physician's signature.

Applications will be time-stamped in the order they are received. If any part of the registration packet is incomplete, you will be placed on stand-by. Once the entire packet is complete, you will receive a confirmation letter by mail or email.

We recommend that you invest the time to read Camp Bloomfield's Camper Handbook to better assist you in the registration process and to learn more about how to enjoy a smooth transition to camp. A copy of the handbook can be found online at https://www.wayfinderfamily.org/program/camp-bloomfield or can be provided by request.

We look forward to an exciting summer with you!

Sincerely,
The Camp Bloomfield Staff

5300 Angeles Vista Boulevard · Los Angeles, California 90043 · Phone: (323) 295-4555 · Fax: (310) 321-3493 · www.wayfinderfamily.org

Camp Bloomfield Adult Camp Registration Packet

(Please type or print in BLUE or BLACK ink)

ADD PICTURE HERE
(2″x2″)

Session (check):

☐ **Adult Camp**
Thursday, August 9 – Monday, August 13, 2018
Ages 18 and over

Last Name:	First Name:	Email (Mandatory):

Do you prefer being contacted through email?:
☐ Yes ☐ No

Are you new to camp?:
☐ Yes ☐ No

Vision:
☐ Totally Blind
☐ Light perception
☐ Legally Blind (20/200 or <20% field)
☐ Low Vision (20/70)

T-Shirt size:
☐ S
☐ M
☐ L
☐ XL
☐ XXL

Ethnicity (Check all that apply):
☐ Caucasian
☐ Hispanic
☐ African American
☐ Asian
☐ Native American
☐ Other

Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Mailing Address:	City: State:	Zip Code: County (i.e. Los Angeles):

Have you changed addresses in the past 6 months? (Check one): ☐ Yes ☐ No

Home Phone Number:	Cell Phone Number:
Are you bringing an Aide? ☐ Yes ☐ No	If yes, name of Aide that will be accompanying you to Adult camp:

For Sighted Aides only – Name of camper you are accompanying:

Signature of Adult: ____________________________________ Date: __________

HEALTH HISTORY QUESTIONNAIRE

All information provided in this questionnaire is kept strictly confidential and will become part of your medical record. Please type or print in blue or black ink. All documentation must be in English.

Last name:	First name:	Date of birth:	Age:
Height:	Weight:	Gender: ☐ Male ☐ Female	

EMERGENCY CONTACT INFORMATION (NOT PARENT OR GUARDIAN)	
Name:	Relationship:
Address:	Phone:
Name:	Relationship:
Address:	Phone:
Camper medical insurance provider (Includes Medi-Cal & Medicare):	Policy #:

VISION HEALTH			
Visual impairment diagnosis:		Date of last eye exam:	
Age of onset: __________ ☐ Birth	☐ Illness	☐ Accident	☐ Unknown
Has participant had any eye treatments or surgeries?	☐ Yes	☐ No	
If yes, please explain:			

DISABILITIES AND MEDICAL CONDITIONS		
Please check if participant has any of the following disabilities:		
☐ Cerebral Palsy	☐ Multiple Sclerosis	☐ Muscular Dystrophy
☐ Intellectual Disability	☐ Down Syndrome	☐ Autism
☐ ADD/ADHD	☐ Depression/Emotional Disorders	☐ Behavioral Disorder
☐ Seizures or Epilepsy (if yes, please provide additional information in the designated spaces on the right)	If yes, please explain.	
	Date of last seizure:	Typical seizure duration:
	Frequency:	Potential triggers:
Other:		
Please check if participant has or has had any of the following medical conditions:		
☐ Diabetes	☐ Psychiatric Treatment	☐ Deaf or Hard of Hearing
☐ Cancer	☐ Stroke	☐ Heart Disease
☐ High Blood Pressure	☐ Heart Attack	☐ Irregular Heartbeat or Heart Murmur
☐ Anemia	☐ Sickle Cell Disease	☐ Blood Clots

☐ Thyroid Disease	☐ Kidney Disease	☐ Ear Infections
☐ Sinus Infections	☐ Bladder Infections	☐ Mononucleosis
☐ Chicken Pox	☐ Mumps	☐ Pneumonia
☐ Skin Problems	☐ Alcoholism	☐ Drug Addiction

☐ Asthma (if yes, please provide additional information in the designated spaces on the right)	If yes, please explain.			
	Date of last attack:	Does the camper use an emergency Inhaler?	☐ Yes	☐ No
	Potential triggers:			

ALLERGIES Please check and briefly describe reaction if participant has or has had any of the allergies listed below.		
Does participant use an EpiPen? If yes, EpiPen must be properly labeled with a pharmacy label including name and directions.	☐ Yes	☐ No

☐ Bee stings	☐ Insect Stings – Please specify:	☐ Latex
☐ Peanuts	☐ Dairy / Lactose Intolerance	☐ Penicillin

☐ Food – Please list and explain all:	☐ Medication – Please list and explain all:
Any other allergies, please list and explain:	

PHYSICAL AND INDEPENDENCE SKILLS			
Physical Limitations	Does participant use a walker?	☐ Yes	☐ No
	Does participant use crutches?	☐ Yes	☐ No
	Does participant use a wheelchair?	☐ Yes	☐ No
	Does participant have trouble walking/standing for long periods of time?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		
Independence Skills	Does participant need help using the toilet?	☐ Yes	☐ No
	Does participant have a history of bed-wetting?	☐ Yes	☐ No
	Does participant need help showering?	☐ Yes	☐ No
	Does participant have sleep disorders or sleepwalk?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		
Dietary Considerations	Does participant need help feeding himself or herself?	☐ Yes	☐ No
	Is participant a vegan or vegetarian?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		

HOSPITALIZATIONS AND SURGERY HISTORY	
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**

Please feel free to add any additional information or special notes for the camp nurse that will enhance the camper's experience at Camp Bloomfield:

____

____

____

____

____

____

____

____

____

I hereby grant permission for the camp nurse to dispense over the counter medications to camper as needed such as: Tylenol, Motrin, Benadryl, Robitussin, Claritin, Sudafed, Dramamine, Vitamin C, Cepacol Lozenges, Maalox, Pepto Bismol, Milk of Magnesia, Metamucil, Cortisone Cream, Antifungal Cream, Neosporin Ointment, Hydrogen Peroxide, Saline, Iodine and Alcohol swabs to clean and prepare skin.

Please circle one: **YES** or **NO**

Please print Adult Participant Name: ____

Signature of Adult Participant: ____Date: ____________

I certify that the above information is true to the best of my knowledge.

Please print Adult Participant Name: ____

Signature of Adult Participant: ____Date: __________

MEDICATIONS Please complete with all medications and supplements you will be bringing and taking at camp.

THIS BOX FOR ADULTS ONLY: Medication administration choice: (Please initial one choice)

______ I am independent with my medications and will not require assistance. I am aware that my medications will be stored in the infirmary for safety reasons and that they will be available to me at meal times, bedtime, and other times as needed.

______ I am requesting assistance with my medications and would like the nurse to dispense my medications to me as prescribed. I am aware that all medications and supplements must be in their original containers with prescriptions having correct dispensing information.

Prescribed Medication (APPLIES FOR ALL PARTICIPANTS) Routine, as needed, or over the counter	Dosage	Times

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Adult Participant: X ____Date: _________

Signature of Camp Nurse: X ______________________________________Date: ___________________

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Adult Participant: X ____Date: _________

Signature of Camp Nurse: X ______________________________________Date: ___________________

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Adult Participant: X ____Date: _________

Signature of Camp Nurse: X ______________________________________Date: ___________________

SELF-DISCLOSED IMMUNIZATION HISTORY

All information provided in this questionnaire is kept strictly confidential and will become part of your medical record. Please type or print in blue or black ink. All documentation must be in English.

1. Date of last tetanus shot given: ______________________________

   Last tetanus shot must have been completed in the last ten years. If camper Frankie has a tetanus shot dated June 1, 2006, his shot is valid until June 1, 2016.

2. Date of last tuberculosis skin test given: ______________________________

   Results: ☐ Negative ☐ Positive

3. If you have any physical conditions or other medical conditions that require restricted participation in camp activities, please list and explain below:

____

____

____

____

____

____

Please provide a copy of immunization records for your camp file.

By signing below, you (the Adult Participant) are attesting that all immunizations are up to date as reported on this form.

Print name of Adult:____

Signature of Adult: ______________________________ Date: ____________

Last Name:	First Name:	Middle Name:

AUTHORIZATION FOR TREATMENT OF ADULT CONSENT, RELEASE, AND COVENANT

I, the adult (age 18 and over) participant, agree to participate in the programs of Wayfinder Family Services of America, and for purposes of said participation agree, authorize, and state as follows:

In case of medical or dental need or emergency, I, as the adult participant, do hereby authorize Wayfinder Family Services of America and its officers or staff employees as agent(s) to obtain and consent to any x-ray examination, anesthetic, medical, dental, surgical diagnosis, treatment and hospital care which is deemed advisable by, and is to be rendered to me under the general or special supervision of any surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital or by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis of treatment is rendered at the office of said physician or dentist or at the said hospital.

I also understand and agree that any and all such medical, dental, hospital or similar expenses incurred in the treatment me the participant will be borne by me. I understand that no representation of such coverage exists or is intended by this form.

It is understood that this authorization is given in advance of any specific medical or dental diagnosis, treatment or care being required but is given to provide authority and power on the part of Wayfinder Family Services (as aforesaid) as my (our) agent(s), to give specific consent to any and all such diagnosis, treatment or care which a licensed physician or dentist in the exercise of his/her best judgment may deem advisable. The authorization is given pursuant to the provisions of Sections 25.8 of the Civil Code of California.

This authorization shall remain effective while the adult participant is enrolled in Wayfinder Family Services' Recreation Programs, unless sooner revoked in writing and delivered. The adult participant further releases Wayfinder Family Services, its officers, agents, and employees from any and all legal responsibility for accidents or sickness occurring during or related to the period of time said person is a participant in programs of Wayfinder Family Services of America. I further agree and covenant (for valuable consideration, receipt of which is acknowledged) that neither said person or I will institute any suit or action of damage, loss or injury of any kind, whether to person or property, whether to me, individually, to the programs or activities of Wayfinder Family Services (including but not limited to Camp Bloomfield) in which the person participates.

Adult Initials: ______

Current Medical Insurance is mandatory in order to participate in any recreation activity or event. Any medical costs incurred while participating in any of Wayfinder Family Services' Recreation Programs (including Camp Bloomfield) shall be the responsibility of the adult participant. Medical costs include: physician visit, emergency room visit, prescription medication, and/or emergency transportation. It is also to be understood and agreed that any and all such medical, dental, hospital, or similar expenses incurred in the treatment of the adult participant will be borne solely by him or her. If a situation requires medical treatment, the provided emergency contact will be contacted by a staff member and informed of the situation. Should a situation arise, the participant will be taken to the local emergency facility for treatment.

Adult Initials: ______

I have carefully read information above, clearly understand, and voluntarily sign this Form agreement.

I HAVE READ AND WILL PROVIDE A COPY OF:

MEDICAL INSURANCE CARD

or

State of California/Benefits Identification Card (MEDI-CAL)

Print name of Adult:____

Signature of Adult: ____ Date: __________

Last Name:	First Name:	Middle Name:

Please read the following information very carefully. Select one arrival option and one departure option, and sign at the bottom of the form.

ARRIVAL OPTION (Select only one option):

☐ **Wayfinder Family Services, 5300 Angeles Vista Blvd., Los Angeles, CA 90043**
I (ADULT) will check in at Wayfinder Family Services' gym (back gate off of 54th Street) on the first day of the session at **8:00 a.m.** If I arrive late, I understand that Wayfinder Family Services ***is not*** responsible for transporting me to camp.

☐ **Camp Bloomfield**, **35375 Mulholland Hwy., Malibu, CA 90265**
I (ADULT) will check-in at Camp Bloomfield on the first day of the session **at 12:30 p.m.**

☐ **LAX or Oxnard Transportation Center**
I (ADULT) will arrive via LAX Airport or Oxnard Transportation Center on the first day of the session **between 7:00 a.m. and 9:00 a.m**. **(no exceptions will be made)**. **MANDATORY:** I will include a copy of my travel itinerary and travel reservation confirmation in addition to filling out this form.

DEPARTURE OPTION (Select only one option):

☐ **Wayfinder Family Services, 5300 Angeles Vista Blvd., Los Angeles, CA 90043**
I (ADULT) will take the bus from Camp Bloomfield to Wayfinder Family Services on the last day of the session. I understand that the bus will arrive at Wayfinder Family Services (back gate off of 54th Street) at **10:30 a.m**. and that I am responsible for my own transportation from Wayfinder Family Services.

☐ **Camp Bloomfield**, **35375 Mulholland Hwy., Malibu, CA 90265**
I (ADULT) will check out on the last day of the session from Camp Bloomfield **between 9:00 a.m. and 10:00 a.m.**

☐ **LAX or Oxnard Transportation Center**
I (ADULT) will depart via LAX Airport or Oxnard Transportation Center on the last day of the session **between 9:00 a.m. and 11:00 a.m. (no exceptions will be made).**

I (ADULT) have carefully read and clearly understand the procedure regarding arrival and departure. Cabin and counselor assignments will only be given after the adult has been properly checked-in.

Print name of Adult:____

Signature of Adult: ____________________________________ **Date:** __________

Camp Bloomfield Adult Camp Registration Packet

Last Name:	First Name:	Middle Name:

ACTIVITY OPT-OUT

I (ADULT) have **checked off** the following activities in which I **DO NOT** want to participate in:

☐ Archery	☐ Golf	☐ Arts & Crafts	☐ Climbing Wall
☐ Ropes Course	☐ Hiking	☐ Tandem Bikes	☐ Evening Activities
☐ Horseback Riding	☐ Drama	☐ Outdoor Living Skills	☐ Swimming (Beach)
☐ Swimming (Pool)	☐ Goalball	☐ Nature	☐ Beep Baseball
☐ Tee-Pee Overnighter	☐ Extended Hiking	☐ and/or Other: ____________________	

Adult's swimming ability (check one): ☐ Non-Swimmer ☐ Beginner ☐ Intermediate ☐ Advanced

Please note that all adults, regardless of noted swimming ability, are required to take and pass the swim test and pass in order to access the deep end of the pool (5-10 feet).

I (ADULT) agree to participate in all the activities offered by or through Camp Bloomfield, with the exception of those activities that were checked off above. I hereby join in the foregoing Activity Opt-Out Form and hereby stipulate and agree to save and hold harmless, indemnify, and forever defend Camp Bloomfield, their directors, officers, agents, employees, and volunteers from and against any claims, actions, demands, expenses, liabilities (including reasonable attorney fees) for negligence as a result of my participation in the activities of Camp Bloomfield and my use of the property, animals, and facilities. I further agree not to sue Camp Bloomfield, its directors, officers, agents, employees, and volunteers as a result of any injury that I may suffer from negligence in connection with the participation of the activities at or connected with Camp Bloomfield.

I (ADULT) have no health or physical condition that will interfere with the activities stated above or cause me to be more susceptible to injury than the average person. If any health conditions are present, I assume the risks associated with any such health or physical condition.

Print name of Adult: ____

Signature of Adult: ____ Date: ____________

CABIN ASSIGNMENTS

Adult Last Name: ______________________ First Name: ______________________

If you have a medical condition that requires you to need a bottom bunk accommodation please specify in the space provided below, otherwise bunk accommodations are on a 'first come, first serve' basis.

If you would like to share a cabin with a friend during your stay, please submit the friend's name(s) to assist staff during cabin assignments. However, your request **must** be approved and is not guaranteed. **(Please print)**

Full Name: ________________ Full Name: ________________ Full Name: ________________

Full Name: ________________ Full Name: ________________ Full Name: ________________

Full Name: ________________ Full Name: ________________ Full Name: ________________

Signature of Adult: ____ Date: ____________

Last Name:	**First Name:**	**Middle Name:**

MEDIA RELEASE

Permission is hereby given to WAYFINDER FAMILY SERVICES® to use audio, video recordings, photographic and electronically created images of ________________________________ (Adult's name) for public view, including publications, websites or social media sites. Usage of any images or audio is without compensation to said person or to the undersigned on his/her behalf, or individuality.

On occasion, specific students are identified for profile stories used in grant applications and reports, publications, websites or social media sites. Permission is hereby given to WAYFINDER FAMILY SERVICES® to publish in grant applications and reports, publications, websites or social media sites, ____________________ (Adult's name) story with related quotes, after verbal and/or written approval of that story has been granted by said person or by the undersigned on his/her behalf or individuality.

Address: ____

City, State, Zip Code: ____

Phone: ____

Print name of Adult:____

Signature of Adult: ____ **Date:** __________

INCOME INFORMATION *(For reporting purposes only)*

Please answer the following questions as they apply to your household (including the participant):

1. How many adults reside in the home? ______ 2. How many children reside in the home? _______

3. What is your household's combined gross annual income from all sources? $__________________

HOW DID YOU HEAR ABOUT CAMP BLOOMFIELD?
Check all that apply

- ☐ Returning Camper
- ☐ A friend or family member
- ☐ A Wayfinder Family Services staff member
- ☐ Department of Rehabilitation Counselor
- ☐ Teacher of Students with Visual Impairments (TVI)
- ☐ Received brochure in the mail
- ☐ Email
- ☐ Social media
- ☐ Wayfinder Family Services website
- ☐ Other:

ADULT MEDIATION AND ARBITRATION AGREEMENT

This is an Agreement to mediate and arbitrate all unresolved disputes arising from the educational, recreational, special education school, and residential services between the undersigned student and/or their legal guardian and the Wayfinder Family Services.

In the event of any unresolved dispute, claim or controversy by the student and/or their legal guardian against Wayfinder Family Services, its directors, officers, employees or agents, the student and/or their legal guardian agrees to submit such unresolved dispute, claim or controversy, including but not limited to all claims for breach of contract and civil torts, to non-binding mediation before a neutral independent third-party mediator and, if that process does not result in full resolution of the dispute, to final and binding arbitration, including, but not limited to, claims for breach of contract and civil torts.

The arbitration shall be conducted by a single-arbitrator selected either by mutual agreement of the student and/or their legal guardian and the Wayfinder Family Services or, if they cannot agree, from an odd-numbered list of experienced arbitrators provided by the American Arbitration Association. Each party shall strike one arbitrator from the list alternately until one arbitrator remains.

The arbitrator shall have all powers conferred by law and a judgment may be entered on the award by a court of law having jurisdiction. The award and judgment shall be in writing and binding and final on both parties.

Each party shall have the right to conduct reasonable discovery, as determined by the arbitrator and as provided in California Code of Civil Procedure Section 1283.5(a).

The parties agree to submit any unresolved dispute or unresolved controversy arising out of or relating to the terms of the Agreement to mediation, and if that process does not result in full resolution of the dispute to final and binding arbitration by a single neutral arbitrator.

Wayfinder Family Services agrees to pay for 75% of the costs of the mediation and arbitration proceedings and the fees of the arbitrator. The remaining 25% of the costs and fees of the mediation and arbitration will be paid by the student and/or their legal guardian. Recognizing that parties involved in any such dispute may have limited resources, the parties agree to endeavor in good faith to identify a mediator and an arbitrator whose fees and costs are reasonable and affordable in light of that fact.

This agreement shall continue during the period of service delivery and thereafter regarding any related disputes. This agreement may only be modified for the Wayfinder Family Services by a written agreement signed by the President of the Wayfinder Family Services.

The student and/or their legal guardian understand that by signing this Agreement, he/she gives up his/her right to a civil trial and his/her right to a trial by jury.

If any of the provisions of this Agreement are found null, void, or inoperative, for any reason, the remaining provisions will remain in full force and effect.

I have read, understand, and received a copy of this document.

Print name of Adult: ____

Signature of Adult: ____ Date: _______________

Signature of Authorized Representative for Wayfinder Family Services (Donald Ouimet, Vice President of Programs):

X____Date: ___________

Camp Bloomfield Adult Camp Registration Packet

NOTICE OF PRIVACY PRACTICES

The privacy of your personal and health information (PHI) is important to us. This notice describes how your PHI may be used and disclosed and how you can have access to this information.

Protecting Your Personal Health Information

Wayfinder Family Services understands the importance of keeping your PHI private. In accordance with the State and Federal Law, this notice describes Wayfinder Family Services' privacy practices. We may modify or change our privacy practices from to time to time, particularly as new laws and regulations become effective. When that occurs, we will provide you with a new notice advising you of the changes. For more information about our confidentiality and privacy practices, or for additional copies of this notice, please contact us.

Wayfinder Family Services may use and disclose your PHI without your authorization *only* in the following ways:

- **Treatment:** Your PHI to a provider who requests this information to treat you
- **Payment:** To pay claims for covered services provided to you
- **Health Care Operations:** To conduct quality improvement activities, to engage in care coordination and case management, and other similar activities
- **Health and Wellness:** To contact you with information about health-related services, appointment reminders or treatment alternatives
- **Family and Friends:** To a family member, friend or other person if you are unavailable to agree, such as in a medical emergency or disaster relief, only to the extent necessary to help with your health care or with payment of your care
- **Public Health and Safety:** To avert a serious and imminent threat to your health or safety or the health or safety of others

I acknowledge that I have reviewed and received a copy of Wayfinder Family Services' Privacy Practice Form.

Print name of Adult:____

Signature of Adult: _________________________________ Date: __________

End of Application

Please return completed application packet to:

Wayfinder Family Services
Attention: Joshua Lucas
5300 Angeles Vista Blvd. Los Angeles, CA 90043

Fax: (310) 321-3493

jlucas@wayfinderfamily.org

Your completed application packet should include all application forms, a 2″x2″ photo of the adult camper, a check or money order for $25 made payable to Wayfinder Family Services, a copy of the adult camper's medical insurance or Medi-Cal card, and a travel itinerary and/or travel reservation confirmation, if applicable (see form 5).

For questions regarding registration or your stay at Camp Bloomfield:

Please contact Joshua Lucas at (323) 295-4555, ext. 272
or jlucas@wayfinderfamily.org