Wayfinder
FAMILY SERVICES
Together, we'll reach new heights.

It's Camp Bloomfield time!

Thank you for your interest in **Camp Bloomfield's 2019 Sessions!** We're very excited to have you join us this summer for Camp Bloomfield happening at **Point Fermin Outdoor Education Center located at Barlow Saxton Road, San Pedro, CA 90731.**

At Camp Bloomfield, you will have the opportunity to participate in traditional camp activities such as sports, music, arts and crafts, swimming, nature classes, hiking, visits to the Marine Mammal Care Center, field trips to the USS Iowa, and much more!

The camp sessions for this summer are as follows:

Youth Camp (Ages 8-12)

Campers who are blind or visually impaired can make friends and increase their independence skills as they participate in swimming, arts & crafts, music, nature classes, field trips to the beach, visit to the Marine Mammal Care Center, adapted sports, and more! Special events include an Evening Campfire Programs and Awards Night.

Teen Camp (Ages 13-18)

Campers who are blind or visually impaired can make friends and increase their independence skills as they participate in swimming, arts & crafts, music, nature classes, adapted sports, field trip to the USS Iowa, visit to the Marine Mammal Care Center and more! Special events include Deep Sea Fishing trip, Evening Campfire Programs, and Awards Night.

Challenge Camp (Ages 12-18)

Campers who are blind or visually impaired are invited to integrate with their peers during Challenge Camp, featuring exciting team-based challenges and games. Participants of this session will leave camp with improved self-confidence, an understanding of teamwork and empowerment to be the best they can be. Special events include Evening Campfire Programs, Ocean Sailing, and Awards Night.

Adult Camp (Ages 18+)

Adult campers who are blind or visually impaired can increase their independence skills as they participate in swimming, arts & crafts, music, nature and sports. Special events include a New Year's Dance, Evening Campfire Programs, Open Mic Night and Awards Night.

The attached camper application packet applies to children and adults, who are blind or visually impaired. If the camper is attending multiple sessions, one application may be used for all sessions. Students ages 18 years of age or older may attend the sessions listed in this application packet only if they are currently enrolled in high school. Adult campers should sign for themselves under parent/guardian signature lines

and do not need to list school or parent information.

Please complete the packet entirely and return it to Wayfinder Family Services **as soon as possible** along with a **2" x 2" portrait photo** 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 camper's parent or guardian (if under 18) and **do not** require a physician's signature. Attachment A is for any camper who takes any prescribed medication. If you need more space to list medications, please attach a separate sheet. Attachment E is only for students who need to carry medication on them at all times (i.e. inhalers, epi-pens, seizure device, etc.) **Attachment A and/or Attachment E need to be signed by a physician.**

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 e-mail. **All check-ins will happen directly at Point Fermin Outdoor School in San Pedro, California. There will be no transportation from Wayfinder campus for any camp session.**

Child campers are also welcome to invite a Sighted Buddy or sibling to attend camp with them. **The fee for a sighted buddy is $200 per session they are confirmed to attend. Cancellations must be given 24 hours in advance of the beginning of the confirmed camp session in order to receive a refund.**

We look forward to an exciting summer with you!

Sincerely,
The Camp Bloomfield Staff

Camp Bloomfield Camper Registration Packet

(Please type or print in BLUE or BLACK ink)

ADD PICTURE HERE (2"x2")

Session(s) of Interest:

☐ **Youth Camp**
Monday, July 8 – Friday, July 12, 2019
Ages 8-12

☐ **Challenge Camp**
Monday, July 15 – Friday, July 19, 2019
Ages 12-18

☐ **Teen Camp**
Monday, July 22 – Friday, July 26, 2019
Ages 13-18

☐ **Adult Camp**
Tuesday, August 6 – Friday, August 9,2019
Ages 18+

Last Name:	First Name:	Parent's Email (Mandatory):	
Do you prefer being contacted through email? ☐ Yes ☐ No	Vision: ☐ Totally Blind ☐ Light perception ☐ Legally Blind (20/200 or <20% field) ☐ Low Vision (20/70) ☐ Sighted Buddy	T-Shirt size: Youth: ☐ S ☐ M ☐ L Adult: ☐ S ☐ M ☐ L ☐ XL ☐ 2X ☐ 3X	Ethnicity (Check all that apply): ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other
Are you new to camp? ☐ Yes ☐ No	Name of School: School District:	Grade attending in upcoming school year: ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Date of Birth: Age: / Gender: ☐ M ☐ F
Mailing Address:	City: State:	Zip Code: County (i.e. Los Angeles):	
Have you changed addresses in the past 6 months? ☐ Yes ☐ No			
Are you inviting a buddy to camp? ☐ Yes ☐ No		If yes, name of buddy:	
1st Parent/Guardian Name:	Home Phone Number:	Cell Phone Number:	Work Phone Number:
2nd Parent/Guardian Name:	Home Phone Number:	Cell Phone Number:	Work Phone Number:
Name of teacher of the visually impaired (VI or O&M services): Name of school district:		Teacher's email: Work Number:	

Signature of Parent/Guardian: _____ **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 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 Parent/Guardian Name: _____

Signature of Parent/Guardian: _____ **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.

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

Signature of Parent/Guardian: 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 child's camp file.

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

Print name of Parent/Guardian:_____

Signature of Parent/Guardian: _____ **Date:** _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider)

Student name _____ ____ _____ _____
Last First Sex Birth date School

Name of medication _____ Date of prescription _____

Dosage prescribed _____ Time schedule at school _____

Dose form _____ Route _____
(Tablet, liquid, injection, inhalant, etc.)

Purpose of medication or diagnosis _____

Licensed Health Care Provider's Recommendations (Check where applicable)

☐ The medication may have adverse side effects (explain) _____

_____

☐ Special instructions and/or comments _____

_____

The student for whom this medication is prescribed is under my care.

_____ _____ _____
Print name/Title Signature Date

_____ (___)_____
Address City State Zip code Telephone

Print name of Supervising Physician _____ (NP, Midwife, PA)

Furnishing Number _____ (NP/Midwife)

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by parent/guardian)

I request that my child _____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

_____ _____ _____
Date Signature of Parent/Guardian/Student 18 years Printed Name

(____)_____ (____)_____ (____)_____
Home telephone Work telephone Cellular telephone

DISTRICT PROCEDURES REGARDING MEDICATION TAKEN DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

   - Student's full name
   - Physician's name
   - Dosage, schedule, route and dose form.
   - Date of expiration of the medication

2. In addition to a home supply, parent/guardian may request a second labeled bottle from the pharmacy for school use.

3. Non-prescription (over the counter) medications that have been authorized by this request, may be administered at school only if the medication is provided in the original container.

4. Requests For Medication Taken During School Hours must be renewed annually.

5. Parent/Guardian will notify the school nurse or site administrator and provide a new *Request for Medication to Be Taken During School Hours* when there is a change in the student's medication, health status or authorized health care provider.

6. The school administrator or the administrator's designee will assume responsibility for placing the medication in a locked cabinet, storage unit or locked refrigerator.

7. The school administrator, the administrator's designee, or school nurse will assume responsibility for returning unused medication to the parent/guardian at the end of the student's school year.

8. If medication must be taken while a student is on a field trip, arrangements must be made through the school nurse.

9. All injectable medications require special arrangements.

   a. Injectable medications, such as insulin, used on a regular or as needed basis must be administered by licensed health care providers and require special arrangements.

   b. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

33.199 E/S Rev. 3/07

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name _____ First Name _____ Sex _____ Birth date _____ School _____

Name of Medication _____ Dose Form: (Tablet, Liquid, Injection, Inhalant, etc.) _____

Dosage Prescribed _____ Time/Frequency _____ Route (Mouth, Ear, Eye, Etc.) _____

Purpose of medication or diagnosis _____

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

This student's medical condition requires immediate use of _____ (medication) and the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____

☐ Special instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider _____ Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____ ( ) Telephone _____

Print name of Supervising Physician (if N.P., Midwife or P.A.) _____ Furnishing Number (if N.P. or Midwife) _____

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

Print name of parent or guardian _____ Signature _____ Date _____

( ) Telephone _____ ( ) Work telephone _____ ( ) Cellular telephone _____

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal _____ Signature of School Nurse _____ Date _____

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

   - Student's full name
   - Physician's name
   - Dosage, schedule, route and dose form.
   - Date of expiration of the medication

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Administration of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication.

Camp Bloomfield Camper Registration Packet

Last Name:	First Name:	Middle Name:

AUTHORIZATION FOR TREATMENT OF ADULT CONSENT, RELEASE, AND COVENANT

The undersigned parent/guardian represents to Wayfinder Family Services that the minor named below is in his and/or her legal custody and control; and that the undersigned desires said minor to participate in the programs of Wayfinder Family Services, and that for purposes of said participation the undersigned agrees, authorizes and states as follows:

In case of medical or dental need or emergency, I (we) understand every effort will be made to contact parents/guardians of children. In the event I (we) cannot be reached, I (we) undersigned, parents/guardians of camper, do hereby authorize Wayfinder Family Services and its officers or staff employees as agent(s) for the undersigned 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 said minor 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 (we) also understand and agree that any and all such medical, dental, hospital or similar expenses incurred in the treatment of my (our) child will be borne by myself (ourselves). We 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 child is enrolled in Wayfinder Family Services' Recreation Programs, unless sooner revoked in writing and delivered. The undersigned 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. I (we) further agree and covenant (for valuable consideration, receipt of which is acknowledged) that neither said person or I (we) will institute any suite or action of damage, loss or injury of any kind, whether to person or property, whether to me (us), individually, or as parents/guardians relating to the programs or activities of Wayfinder Family Services (including but not limited to Camp Bloomfield) in which the person participates.

Parent/Guardian Initials: _____

Current Medical Insurance is mandatory in order to participate in any recreation activity or event. Any medical costs incurred while participating in any Wayfinder Family Services' Recreation Program (including Camp Bloomfield) shall be the responsibility of the participant's parent or guardian. 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 participant will be borne solely by the parent or guardian. If a situation requires medical treatment, the parent or guardian will be contacted by a staff member and informed of the situation. Should a situation arise where the parent or guardian cannot be reached, the participant will be taken to the local emergency facility for treatment.

Parent/Guardian Initials: _____

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

I HAVE READ AND WILL PROVIDE A <u>COPY</u> OF:

MEDICAL INSURANCE CARD

or

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

Print name of Parent/Guardian:_____

Signature of Parent/Guardian: _____ Date: _____

Camp Bloomfield Camper Registration Packet

Last Name:	First Name:	Middle Name:

AUTHORIZED RELEASE OF CAMPER

(Applies to Campers under 18 years of age)

Session(s) Camper is attending: _____

I hereby authorize the following person(s) to check in my child during registration and/or pick up my child at the end of the session or in the event of an emergency. When picking up the Camper, the authorized individual **must** show a valid ID.

First Name: _____ Last Name: _____ Relationship: _____

First Name: _____ Last Name: _____ Relationship: _____

First Name: _____ Last Name: _____ Relationship: _____

Signature of Parent/Guardian: _____ **Date:** _____

ACTIVITY OPT-OUT

I have **crossed out** the following activities in which I **DO NOT** want my child 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	☐ Field Trips	☐ and/or Other: _____	

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

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

I hereby grant camper named above permission to participate in all activities offered by or through Camp Bloomfield, with the exception of those activities that were crossed out above. The undersigned parent, guardian, or custodian of the above named camper hereby joins in the foregoing Activity Opt-Out Form and hereby stipulates and agrees 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 said camper's participation in the activities of Camp Bloomfield and his or her use of the property, animals, and facilities. I, on behalf of said camper, further agree not to sue Camp Bloomfield, its directors, officers, agents, employees, and volunteers as a result of any injury that said minor suffers from negligence in connection with his/her participation in the activities of Camp Bloomfield.

I represent that said camper have no health or physical condition that will interfere with the activities stated above or cause him/her 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 Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date:** _____

Camp Bloomfield Camper Registration Packet

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 _____ (Camper'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, _____ (Camper'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 Parent/Guardian: _____

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

Camp Bloomfield Camper Registration Packet

CAMPER/PARENT/GUARDIAN 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 camper and/or their legal guardian and the Wayfinder Family Services.

In the event of any unresolved dispute, claim or controversy by the camper 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 camper 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 camper 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 camper 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 Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Authorized Representative for Wayfinder Family Services (Allison Burdett, Executive Director of Visual Impairment & Developmental Disabilities Services):

X_____Date: _____

Camp Bloomfield Camper 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 Parent/Guardian:_____

Signature of Parent/Guardian: _____ Date: _____

Wayfinder
FAMILY SERVICES
Together, we'll reach new heights.

End of Application

Please return completed application packet to:

Wayfinder Family Services
Attention: Marco Diaz
5300 Angeles Vista Blvd. Los Angeles, CA 90043

Or

Fax application to: (310) 321-3493

Or

Scan and e-mail application to: mdiaz@wayfinderfamily.org

Your completed application packet should include all application forms, a 2"x2" photo of the camper, a copy of the adult camper's medical insurance or Medi-Cal card.

For questions regarding registration or your stay at Camp Bloomfield:

Please contact Marco Diaz at (323) 295-4555, ext. 292
or mdiaz@wayfinderfamily.org

"Use of the school premises has been granted pursuant to the provisions of Sections 17400, et seq., of the Education Code of the State of California to (WAYFINDER FAMILY SERVICES) from the Board of Education of the Los Angeles Unified School District. LA Unified and the Board of Education does not sponsor or take responsibility, nor does it endorse any of the activities, statements or opinions which may be expressed at this meeting/activity."