Camper Enrollment 2013-2014

INFORMATION

Youth Haven Camps and Retreats Eligible Applicants:

__ Camper or direct family member positive for HIV/AIDS*

*status must be disclosed to camper

__ Ages 7 (grade 2) through 21 (high school-community college student)

__ Resident of Washington, DC, Maryland or Northern Virginia

There is NO income requirement or fee charged to campers.

Campers selected according to space available and suitability for program.

Please Note!

All children and youth attending overnight camps must also turn in health forms signed by their doctor or clinic. Download these forms from the LSS/NCA website. They are good for 12 months.

___ **Health History and Physical** (3 pages)—completed by health care practitioner—

*Use student's current copy of DC "Universal Health Certificate" or use attached (pages 1-2)

*Health Certificate must be dated within 1 year of camp session

*Medications Orders (page 3) must be completed by health care practitioner

___ **Behavioral Health** (1 page)—completed by social worker or psychiatrist

Health Information Privacy Statement:

The health information disclosed on this application is maintained in private client files under the supervision of the Nursing Coordinator, and disclosed only to authorized camp staff. Disclosure to other health providers is authorized through this application by the camper's parent/guardian and is limited to cases of emergency medical treatment while the camper is in the care of the camp/retreat program.

LSS/NCA will not disclose health information to any other agency for any other reason without additional written release by the applicant's parent or guardian.

Lutheran Social Services / NCA
Teen Haven Retreats
4406 Georgia Ave., NW
Washington, D.C. 20011

LUTHERAN SOCIAL SERVICES
National Capital Area

More Info: contact :...
Phone: 202-723-3000 ext. 261
E-mail: youthhaven@lssnca.org
FAX: 202-723-3303 Attn: Youth Haven

YOUTH HAVEN

Camper Annual Enrollment 2013-14

Please print carefully. Do not leave any blanks.

Submit to:	YOUTH HAVEN	
	Lutheran Social Services/NCA	Email: YouthHaven@Lssnca.org
	4406 Georgia Ave, NW	
	Washington, DC 20011	FAX: 202-723-3303

Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender : M / F School Grade: _____

Street: _____Apt _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____

Relationship to camper: _____

Phone 1: (_____)_____ Phone 2: (_____)_____

Email address: _____@_____

School name: _____ School district: _____

LUTHERAN SOCIAL SERVICES
National Capital Area

Camper name _____

CAMPER BACKGROUND INFORMATION

Is the camper new to Youth Haven programs? ____ Yes ____ No

Who in the family is positive for HIV?

_____

_____

Is the camper aware? ____ Yes ____ No

When was disclosed to the camper? _____

Briefly describe the camper's **living situation and social history**. Please include guardianship, deaths and serious illness in the family, behavior patterns, favorite things, helpful suggestions for working with the camper.

_____

_____

_____

_____

_____

_____

Please list any camps the applicant has attended in the past two years:

_____

Describe any physical, mental, or emotional limitations the camper may have, and special needs or facilities required to accommodate these (i.e. walker, wheelchair, asthma).

Any activities the child should **NOT** do (i.e. swimming, physical activity)? ____ Yes ____ No

_____

_____

_____

_____

_____

_____

Camper name _____

ALLERGIES / FOOD RESTRICTIONS

Please write any allergies you believe your child has (FOOD, BEE STINGS, MEDICATIONS, GRASSES, TREES, etc.)
as well as any food restrictions (ie. vegetarian, Kosher)

1_____

2_____

3_____

4_____

5 _____

Does your child have an "EpiPen" for severe allergic reactions? ___YES ___NO

Does your child have a rescue inhaler for asthma attacks? ___YES ___NO

PERMISSION TO RECEIVE OVER-THE COUNTER MEDICINES

Please CHECK any medications listed below that you WILL ALLOW your child to be given by the nursing staff:

_____ IBUPROFEN _____ TYLENOL _____ NON-NARCOTIC COUGH SYRUP _____ BENADRYL

_____ SUNBLOCK _____ OTHERS (list) _____

Does camper prefer a special drink with their medications? _____

SIGNED X_____ DATE _____

Signature of Parent or Guardian

ADDITIONAL GENERAL COMMENTS

HOW CAN CAMP STAFF SUPPORT YOUR CHILD?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Camper name _____

EMERGENCY CONTACT INFORMATION

Parent / Guardian Name _____

Home Phone _____ Work / Cell Phone(s) _____

If Parent / Guardian is not available please call: _____

Phone(s) _____ Relationship _____

Is this person aware of your family's HIV status? _____YES _____NO

Primary Physician Name _____

Phone(s) _____ Pager/Answering Service _____

Secondary Physician Name _____

Phone(s) _____ Pager/Answering Service _____

Social Worker / Therapist Name _____

Phone(s) _____ Pager/Answering Service _____

Prescribing Physician/Psychiatrist Name _____

Phone(s) _____ Pager/Answering Service _____

Insurance Co._____ Policy # _____

Insurance Co. Phone _____ Group Number _____

Emergency Medical Treatment Authorization

I, _____ do hereby authorize and permit Lutheran Social Services of the National
Parent or Guardian Name
Capital Area (LSS/NCA) to bring my child _____to the hospital or emergency room or clinic
Camper Name
for evaluation and or treatment. I understand that, if possible, my child's primary physician will be contacted so that he/she may participate in this treatment in the event of an emergency. In the event that my child's primary physician is not available, I hereby authorize the physicians and staff on duty at the hospital or clinic to treat my child in the event of such an emergency (illness, accident or other injury). I realize that all costs incurred as a result of this treatment may be billed directly to me if proper payment information is not included above. I understand that LSS/NCA will not be liable for any costs related to emergency treatment of my child. By my signature below, I release LSS/NCA, its entire staff, volunteers, nurses, and support personnel, as well as the medical and administrative staff of the treating hospital or medical facility, local EMTs ambulatory services, clinical staff and nurses, funders, from any and all liability resulting from action caused by such an emergency.

SIGNED _____ **DATE** _____
Signature of Parent or Guardian

Camper name _____

LIABILITY RELEASE

I _____ release Youth Haven Camps & Retreats, Lutheran Social Services/NCA, its directors, medical, volunteer and staff persons and all funders from any and all liability resulting from my (child's) involvement in programs created by Youth Haven. I understand clearly that participants will be with persons who are infected with HIV. I know that in order to be considered for inclusion, all forms must be filled out completely, clearly, and honestly. I understand that every effort will be made to maintain a safe and healthy environment for all those involved in camp activities. It is with this understanding that I release all staff and subsidiary and support staff (including nurses, doctors, hospital workers, administrators, drivers, cooks, counselors, fund-raisers, board members and directors) from any implied or direct liability. I understand that if I/my child requires medical attention, every reasonable effort will be made to contact me or my agents as listed above regarding such treatment. But in case I am un-reachable and treatment is necessary, I provide on additional pages attached here, full medical information including insurance information, as well as a separate release for emergency medical treatment.

SIGNED _____ **DATE** _____

Signature of Parent or Guardian

OR

SIGNED _____ **DATE** _____

Signature of Camper if age 18 or older

PHOTOGRAPHY/PUBLIC RELEASE

Lutheran Social Services takes photos and interviews campers for purposes of promoting and publicizing the camp to financial donors. LSS/NCA policy is to review any photos taken for this purpose to assure the privacy of those who do not wish to be photographed. Occasionally, the camp is contacted by media organizations about its program. It is the policy of Youth Haven and LSS/NCA to carefully screen and monitor any access that newspapers or television outlets might have to the program and its clients. LSS/NCA will not allow any camper to be photographed or interviewed by the press while at camp without a separate written consent by the parent/guardian.

SIGN ONE STATEMENT ONLY

I give permission for me/my child

_____

Camper Name

to be photographed, interviewed or filmed while at Teen Haven. My signature below will allow LSS/NCA to include my child's image in print, on film, or on its Web site.

_____

Parent / Guardian / Self Signature

_____

Date

I DO NOT give permission for me/my child

_____

Camper Name

to be photographed, interviewed or filmed while at Teen Haven, except by other campers or counselors for personal use only. I do not allow photo images to be shared by LSS/NCA in any public way.

_____

Parent / Guardian / Self Signature

_____

Date

Camper name _____

CAMPER DEMOGRAPHIC INFORMATION*

***For statistical purposes only, voluntary**

Camper Race/ethnicity: _____

Persons in household: (number and Relationships)
(example # 7 *Grandmother, Mom, Dad, 2 foster sisters, brother, Aunt*)

_____ _____

Head of household type: ___Biological parent(s) ___Grandparent/kin care ___Foster parent ___Emancipated youth

Housing Status: __Own House ____Rent House or Apartment ___ Living with Relatives

___Living with Non -Relatives ____Homeless

Type of Dwelling: ___House ____Apt. _____ Group Facility ____ Shelter _____Other

Housing Category: ____ Rent ____Public Housing ____Section 8 ___TAP _____ Own((Conventional)

____Own (Subsidized) _____Condo/ Co-op ___None of the above

Camper Enrollment optional

Mar-Lu-Ridge **Rock-Climbing/High-Ropes**

ASSUMPTION OF RISKS

Mar-Lu-Ridge Conference & Educational Center Inc.

The undersigned individual desires to participate in the rock-climbing and/or high-ropes activities at Mar-Lu-Ridge Conference & Educational Center Inc. 3200 Mar-Lu-Ridge Road, Jefferson, Maryland 21755. In consideration for Mar-Lu-Ridge Conference & Educational Center Inc. ("Mar-Lu-Ridge") permitting me to use the Facility, I have agreed to execute this Release of Liability and Assumption of Risks (the "Release"). I acknowledge that using the Facility and participating in the activities sponsored by Mar-Lu-Ridge will involve certain inherent risks, including the risk of death or serious personal injury. I agree to assume all such risks, as well as any other risks involved in using the Facility or participating in any activity involving Mar-Lu-Ridge. I also agree to release and discharge Mar-Lu-Ridge and all of its employees, agents, and representatives, as well as all other persons, corporations or other entities of Mar-Lu-Ridge that might have any liability to me (the "Released Parties"), from and against any and all damages, actions, claims, and liabilities, whether known or unknown, anticipated or unanticipated, suspected or unsuspected, relating to or arising from any activity, occurrence or event involving the Facility or Mar-Lu-Ridge. This Release is intended to release and discharge the Released Parties from all damages, actions, claims and liabilities of any nature, specifically including, but not limited to damages, actions, claims, and liabilities arising from or related to the negligence of the Released Parties. I further agree to indemnify, hold harmless and defend Mar-Lu-Ridge from and against any loss, damage, liability, and expense, including costs and attorneys' fees, incurred by Mar-Lu-Ridge as a result of my using the Facility. The laws of the State of Maryland shall govern the rights and obligations of the parties to this Release and the interpretation, construction and enforceability thereof. I agree that any lawsuit brought against any Releasing Parties shall be brought solely in the Circuit Court for Frederick County. I hereby voluntarily waive any right I may have to a trial by jury in any action, proceeding or litigation involving any Release Party. In addition, I understand that wearing a helmet while climbing in the Facility is required. If I choose not to wear a helmet, I understand that I will not be allowed to participate in the activity.

THIS IS A BINDING LEGAL CONTRACT,
PLEASE READ IT CAREFULLY BEFORE SIGNING.

Date:_____ Date Of Birth:_____

Participant's Name (please print):_____

Address:_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Participant's Signature_____

TO BE SIGNED IF PARTICIPANT IS A MINOR.

I represent that I am the parent or legal guardian of the above individual and hereby contest to the individual using the Facility and participating in any activities sponsored by Mar-Lu-Ridge. In consideration for Mar-Lu-Ridge allowing the above individual to use the Facility I agree, personally and on behalf of the individual, to be bound by the terms and conditions of this form. I further agree to indemnify, hold harmless and defend Mar-Lu-Ridge from and against any loss, damage, liability and expense, including costs and attorneys' fees, incurred by Mar-Lu-Ridge as a result of my using the Facility or participating in any activity involving Mar-Lu-Ridge.

THIS IS A BINDING LEGAL CONTRACT,
PLEASE READ IT CAREFULLY BEFORE SIGNING.

Date:_____ Print name of Parent/Guardian:_____

Parent/Legal Guardian Signature:_____

Address:_____

City_____ State_____ Zip Code_____

For Washington, DC residents ONLY

FY 2014

VERIFICATION OF CUSTOMER ELIGIBILITY FOR CSBG SERVICES FORM

United Planning Organization - Community Services Block Grant Program

Service Provider Name: Lutheran Social Services of the National Capital Area
Address: 4406 Georgia Ave, NW Washington, DC 20011

Participant/Camper's Name: _____
Social Security Number: _____ **Date of Birth:** _____
Street Address: _____
City: _____ **Zip Code:** _____
Home Phone Number: _____ **Work Phone Number:** _____
Total Number in Family Including Yourself: _____

SELECT ONE AND INDICATE AMOUNT:

☐ **Weekly Income: $____** ☐ **Bi-Weekly Income: $_____** ☐ **Semi Monthly Income: $_____** ☐ **Monthly Income: $____**

(A family may be a single individual. For families of more than one individual, the definition of "family" means all persons living in the same household who are: (1) supported by the income of the spouse, parent(s) or guardian(s), and (2) related to the spouse, parent(s) or guardian(s) by blood, marriage, or adoption.)

Annual Family Income Verification Documents (check all that apply)					
Tax Return:	_____	Social Security	_____	Pension/Retirement:	_____
TANF:	_____	Supplemental Security Income:	_____	W2 or 1099:	_____
Child Support:	_____	Military Family Allotments:	_____	No Income:	_____
Alimony:	_____	Training Stipends:	_____	Other:	_____
Explain Other:	_____				

_____ INITIALS (A) I have provided supporting documents to certify that I am eligible to receive CSBG services.

_____ INITIALS (B) I have not provided supporting documents, but by initialing and signing this document, I certify that my income and my family income meets the criteria to qualify for CSBG services.

Certification of Zero Income

I hereby certify that neither I nor my family receive(s) income from any of the following sources:
(a) Wages from employment (including commisson, tips, bonuses, fees, etc.);
(b) Social Security payments, annuities, insurance policies, retirement funds, pension or death benefits;
(c) Allowances such as alimony, child support, or money received from persons not living in my family;
(d) Sales from self-employment resources (Avon, Mary Kay, Shaklee, etc);
(e) Income from operation of a business; (f) Rental income from real estate or property;
(g) Interest or dividends from assets; (h) Unemployment or disability payments
(i) Public assistance payments; or (j) Any other source not named above.

_____ INITIALS (C) I have not provided supporting documents because my income and my family income is zero.

Customer Information: You must initial on the appropriate line above to indicate that you have income and have provided documentation, have income and are unable to provide supporting documents to verify income eligibility but that your family income falls within the poverty guideline or that you have zero income. Additionally, you must sign the form. Note that the information provided on this form is solely for the purpose of determining whether you or your family are eligible for this program and will be kept confidential by UPO and/or its service providers.

Customer/Parent Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE. FOR STAFF ONLY.

Name of Staff Person Verifying Eligibility: _____
Customer's Total Annual Family Income: _____
Is the Customer's Income Below 125% of the Applicable Poverty Level? YES ☐ NO ☐
Is the Customer a Resident of Washington, DC Presently? YES ☐ NO ☐

NOTE: CUSTOMERS FOR WHOM STAFF CANNOT ANSWER YES ON BOTH QUESTIONS ARE INELIGIBLE TO RECEIVE CSBG FUNDED SERVICES PROVIDED BY UPO OR SUBGRANTEES OF UPO.