ASDB'S CAMP LEAP
CAMPERS REGISTRATION CHECKLIST

ASDB'S Camp LEAP IS FOR ANY DEAF, HARD OF HEARING, AND DEAF-BLIND ARIZONA TEENS, ENTERING 8-12 GRADE THE FOLLOWING FALL.

PLEASE ENSURE THAT ALL THE ITEMS BELOW ARE SUBMITTED PRIOR TO REGISTRATION DEADLINE TO HOLD YOUR CHILD'S PLACE IN CAMP.

REGISTRATION WILL NOT BE ACCEPTED/COMPLETE IF THESE ITEMS ARE NOT FULLY COMPLETED AND SUBMITTED.

REGISTRATION CHECKLIST

- ✓ REGISTRATION FORM (ONLINE OR PAPER)
- ✓ PHYSICAL EXAMINATION FORM & MEDICATION LOG (FILLED OUT BY CAMPER'S DOCTOR)
    - NOTE: YOU CHILD WILL NOT BE ALLOWED TO ATTEND WITHOUT A CURRENT PHYSICAL EXAMINATION FORM
- ✓ $200 REGISTRATION FEE
    - CASH ~ IF DROPPING OFF WITH REGISTRATION PACKET AT EITHER CAMPUS
    - CHECK OR MONEY ORDER PAYABLE TO "ASDB" for "Camp LEAP"

MAIL ANY REGISTRATION MATERIALS TO:

ASDB
C/O JENNIFER HENSLEY, DIRECTOR OF DEAF PROGRAMS
800 W. WASHINGTON ST. SUITE 539
PHOENIX, AZ 85007

REGISTER BY **MAY 8, 2020**

ARRIVAL – CAMPERS SHOULD BE DROPPED OFF AT THE ASDB BERGER PERFORMING ARTS CENTER (BPAC) AT **3PM ON SUNDAY, JUNE 7, 2020**. IF YOU ARRIVE EARLY, YOU WILL HAVE TO WAIT IN THE LOBBY WITH YOUR CHILD AS STAFF WILL BE IN TRAINING UNTIL 3PM.

DEPARTURE – CAMPER PICK UP IS BETWEEN **10AM-12PM ON FRIDAY, JUNE 19, 2020** AT 1200 W. SPEEDWAY BLVD., TUCSON, AZ 85745 & THOSE RIDING ASDB BUSSES WILL ARRIVE AT THE PICK UP SITE(S) AT APPROXIMATELY 12-1PM.

SEND QUESTIONS OR COMMENTS ALONG TO JENNIFER HENSLEY, JENNIFER.HENSLEY@ASDB.AZ.GOV, 602-771-5255 (VOICE) OR 602-551-8582 (VIDEO PHONE).

THERE WILL BE PRE-ARRANGED PICK UP/DROP OFF TRANSPORTATION PROVIDED IN VARIOUS LOCATIONS AROUND ARIZONA IF NEEDED. INDICATE THE PREFERRED REGION ON THE REGISTRATION FORM TO SIGN UP & ADDITIONAL INFORMATION ABOUT THE TIME AND LOCATION WILL BE SENT AT A LATER DATE.

ASDB CAMP LEAP
CAMPER APPLICATION

_____

NAME OF CAMPER (LAST, FIRST, MIDDLE) PREFERRED NAME

_____

STREET ADDRESS CITY STATE, ZIP

DATE OF BIRTH _____ SCHOOL ATTENDS _____

GENDER: MALE _____ FEMALE _____ GRADE (FALL 2020) ____

T-SHIRT SIZE – (ADULT SIZES) XS S M L XL 2XL 3XL

HOME PHONE/VIDEOPHONE _____

PARENT/GUARDIAN EMAIL ADDRESS _____

HOW DID YOU LEARN ABOUT US? SCHOOL ONLINE FRIENDS OTHER

PARENT/GUARDIAN INFORMATION

_____

NAME OF PARENT(S) /GUARDIAN

_____

STREET ADDRESS CITY STATE, ZIP

_____

AREA CODE DAY PHONE EVENING PHONE

AUTHORIZED PERSON TO SIGN OUT CAMPER, IF DIFFERENT FROM PARENT/GUARDIAN

_____ _____

NAME PHONE/EMAIL/VP

EMERGENCY CONTACT (1)

_____

NAME RELATIONSHIP

_____

AREA CODE DAY PHONE EVENING PHONE

_____

ADDRESS (CITY) (STATE) (ZIP)

EMERGENCY CONTACT (2)

_____

NAME RELATIONSHIP

AREA CODE DAY PHONE EVENING PHONE

_____

ADDRESS (CITY) (STATE) (ZIP)

GENERAL INFORMATION

Has the camper ever attended camp before? ☐ Yes ☐ No
If Yes, Name of Camp(s):

Please Describe the Camper's Swimming Ability (None/Beginner, Intermediate, Advanced):

Briefly describe the camper's experience with transition (i.e. works with a vocational counselor, works with parents on independent skills, attends a vocational program, etc.):

Additional Information about the camper that we should be aware:

Camper's primary language: ASL, English, Spanish

Camper's secondary language: ASL, English, Spanish

Please describe camper's language use at home (i.e. Sign supported speech, Oral or signed communication):

Does the camper use assistive technology (i.e. hearing aids, CI or Baha)? ☐ Yes ☐ No

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TRANSPORTATION

There will be drop off/pick up locations around Arizona for parents/guardians that are unable to provide transportation for campers to/from ASDB's Tucson campus. In preparation for scheduling transport to remote sites, please indicate which region you would like to drop off and/or pick up your child:

Drop off (June 7, 2020)		Pick up (June 19, 2020)	
Flagstaff	☐	Flagstaff	☐
Phoenix	☐	Phoenix	☐
Yuma	☐	Yuma	☐

Note: You will be contacted with specific drop off/pick up times once they are finalized.

PARENT/GUARDIAN CONSENT

Print Camper Name_____ Print Parent/Guardian Name_____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I/We hereby give my permission to ASDB Camp LEAP to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child (name) _____, should an emergency arise. It is understood that ASDB Camp LEAP will make a conscientious effort to locate parents, and/or any emergency contact listed on this form before any action is taken. I/We will accept the expense of medical or surgical treatment.

Parent(s)/Legal Guardian Signature(s) & Date

NON-PRESCRIPTION MEDICATION

The following non-prescription medications may be stocked by Camp LEAP staff and are used on an as needed basis to manage illness and injury. **Any other non prescription & all prescription medicines must be included on the camper's Medical Forms.**

Acetaminophen (Tylenol)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Ibuprofen (Advil, Motrin)

MOVIE PERMISSION

I/We hereby give permission to watch movies during camp. She/he can watch (check all that apply):
'G' ___, 'PG'___, 'PG-13'___

CONSENT TO TAKING AND USE OF PHOTOGRAPHS

I/We hereby give my permission for photographs to be taken of our child during ASDB Camp LEAP activities, and for publication (i.e. brochure, website, etc.) use reasonably related to the positive promotion of the ASDB Camp LEAP program.

_____

Parent(s)/Legal Guardian Signature(s) & Date

AUTHORIZATION PARTICIPATE OR EXCLUDE PARTICIPATION IN ASDB TRANSITION CAMP'S ACTIVITIES

I/We hereby give my permission for my child to go on field trips away from ASDB Camp LEAP's premises, whether on foot or by authorized vehicle with driver and a chaperone. I give permission for my child to participate in all ASDB Camp LEAP's activities.

Parent(s)/Legal Guardian Signature(s) & Date

INDEMNINIFICATION (WAIVER'S) AGREEMENT

I/we agree to indemnify, hold harmless, and defend ASDB Camp LEAP and their respective employees, agents, and representatives from and against any and all liabilities, claims or demands which may be asserted against any or all of them in connection with our camper's participation in ASDB Camp LEAP. This includes holding ASDB Camp LEAP harmless for any injury which may occur to our camper while traveling to the ASDB Camp LEAP's facility, or while returning from the ASDB Camp LEAP to go home.

Parent(s)/Legal Guardian Signature(s) & Date

Applicants Name	DOB	M: F:

Physician's Examination

HEALTH FORM

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in modified adaptive activities at camp. .

Height	Weight	Pulse	Blood Pressure	Hct/Hgb Test (If appropriate)	Urinalysis (If appropriate)

Please Rate the following:
V-Satisfactory
X-Not Satisfactory
0-Not examined

Eyes	Ears	Nose	Throat	Lungs	Heart	Abdomen	Genitalia	Hernia	Extremities	Posture	Skin	Neuro

Hearing
Please check one

Right Ear	Left Ear

Vision
Please check one

Totally Blind	Legally Blind	Low Vision

General Appraisal
Please address any concerns from above.

Allergies
Please list any known allergies and the applicant's reaction to allergen.

Immunizations

Date of last Tetanus Shot

Are immunizations up to date? **Yes:** **No:**

Current Medical Problems and Treatments
Please attach additional pages if necessary.

Primary Disability

Secondary Disability

Applicants Name	DOB	M: F:

Seizures
Please include seizure type, typical length and frequency, and any known triggers or seizure specific care instructions.

Cardiovascular
Arrhythmias, hypertension, pacemaker, oxygen, etc.

Neuromuscular
Paralysis or loss of muscle function.

Recommendations
List any restrictions of the applicant at camp.

Other Concerns/ Additional Comments
Feeding tube, feeding frequency, ostomy, suctioning, or other necessary assistive

Patient is cleared for 7,000 ft. elevation? **Yes** ☐ **No** ☐

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

I examined the applicant today **Yes** ☐ **No** ☐ | If no, date of examination

Name of Doctor	Signature
Contact Information	Date

ASDB

Camper's Medication Log

HEALTH FORM

Medication Log: *Please fill out and return both forms fully completed with Physicians signature.* **ANY OVC MEDICATIONS DEEMED NECESSARY BY THE PHYSICIAN MUST BE LISTED ON THIS MEDICATION LOG OR THEY WILL NOT BE GIVEN.**

Applicants Full Name | Birthdate

Medications (mg)	Amount Given	Times Given *(Please specify)*	Special Instructions

Doctors Name | Signature

Contact Info