



<b>Office Use Only</b>		ATTACH  CURRENT  PHOTO  HERE  (HEAD & SHOULDERS)
Date Rec: _____	Conf Sent: _____	
Reg. Pd: _____	Paid by: _____	
Balance Due: _____	Paid by: _____	

All sessions of Camp SMILE are held at Camp Grace. If you would like to send mail to your camper send it to:  
 Camper Name  
 c/o Camp SMILE  
 11081 Wanda Dr.  
 Mobile, AL 36608  
**DO NOT SEND APPLICATIONS TO THIS ADDRESS!**

**2010 CAMPER APPLICATION**  
 Send application with a picture of camper and \$35 registration fee to:  
**UCP of Mobile/Camp SMILE**  
**3058 Dauphin Square Connector**  
**Mobile, AL 36607**

Camper wishes to attend:

_____ SMILE I ~ June 29-July 3, 2010	Ages 11-16	<b>Circle One:</b> \$10.00 paid: Yes No  T-shirt: Yes No  Size: YS YM YL AS AM AL XL 2X 3X
_____ SMILE II ~ July 6-10, 2010	Ages *5-10	
_____ SMILE III ~ July 13-17, 2010	Ages 17-23	
_____ SMILE IV ~ July 20-24, 2010	Ages 24-60*	

\*Campers applying, who are outside the age ranges, will be considered on an individual basis

**\*\*\*\*\*IDENTIFYING INFORMATION PLEASE PRINT OR TYPE\*\*\*\*\***

Camper's Last Name	Camper's First Name	Age	Sex	Date of Birth	Parent's Email Address
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Camper's Address	City	St	Zip	County
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Custody Status (check one): \_\_\_\_\_Independent \_\_\_\_\_Parent \_\_\_\_\_Other (please specify)

Legal Guardian's Full Name	Address	City	ST	Zip	Home# Cell# Work#
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Emergency Contact Name	Address	City	ST	Zip	Home# Cell# Work#
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**INSURANCE INFORMATION**

Medicare or Medicaid # \_\_\_\_\_  
 (circle one)

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Group #: \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_ Dr's Office #: \_\_\_\_\_

Hospital Choice: \_\_\_\_\_

**TRANSPORTATION: CAMPERS ARE RESPONSIBLE FOR THEIR OWN TRANSPORTATION**  
 Directions to Camp Grace will be mailed with your acceptance letter.

**DEADLINE FOR APPLICATION IS APRIL 1, 2010**

Camper Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Nature of Disability (please check all that apply):**

Arthritis  Autism/PDD  Attention Deficit Disorder  Cerebral Palsy (walks)  Cerebral Palsy (wheelchair)  Diabetes  
 Down's Syndrome  Hearing Impaired  Heart condition  Learning Disability  Muscular Dystrophy  Seizure Disorder  
 Spina Bifida  Traumatic Brain Injury  Visually Impaired  Non-disabled Other: \_\_\_\_\_  
Mental Retardation (specify level):  Mild  Moderate  Severe  Profound

**Past Medical History**

Asthma  Cardiac  COPD  Diabetes  Hypertension  Shunt  Seizures\*

If camper is subject to seizures, please describe type and frequency: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_ When do seizures most likely occur? \_\_\_\_\_

Camper Immunization's up-to-date?  Yes  No Date of last Tetanus shot: \_\_\_\_\_

Can Camper take Tylenol:  Yes  No Can Camper take Aspirin?  Yes  No

Any illness or hospitalizations in the last 5 years?  Yes  No If yes, please describe: \_\_\_\_\_

**\*If camper has been hospitalized within the last 3 months, a doctor's release is required to attend camp.**

**List ALL DRUG ALLERGIES**, indicating reaction & action to be taken afterward: \_\_\_\_\_

Are there any other significant Medical problems? \_\_\_\_\_

**PERSONAL HISTORY**

Must be completed by parent/guardian or adult applicant.

Name and address of camper's school, rehabilitation program or employer: \_\_\_\_\_

Is camper a CRS client?  Yes  No Has camper attended Camp SMILE before?  Yes  No

How did camper find out about camp? \_\_\_\_\_

**Indicate required assistance or level of involvement with the following:**

**MEALTIME:**

**Eating:**  No assist  Partial assist  Total assist

**Diet:**  Normal  Chopped Food  Blended/Pureed Food  Tube-fed  \*Diabetic

\* please indicate  # of calories/day or  #carbohydrates/meal \* Does camper require a bedtime snack?  Yes  No

Other: \_\_\_\_\_ **(If diet limitations are severe, please list extensive meal options on a separate sheet)**

Does camper have difficulty swallowing?  Yes  No

List special plates, spoons, dentures, etc: \_\_\_\_\_

**List ALL FOOD ALLERGIES**, indicating reaction & action to be taken afterward: \_\_\_\_\_

**HEARING:**

Normal  Mild loss  Moderate loss  Severe loss  Total loss

Hearing aid (Make & Model) \_\_\_\_\_

**COMMUNICATION:**

Non-verbal  Few words  Normal  Sign Language  Gestures

Communication board/device Other: \_\_\_\_\_

\*If camper is non-verbal, please give helpful hints for communicating: \_\_\_\_\_

**PERSONAL HISTORY continued**

**Indicate required assistance or level of involvement with the following:**

**MOBILITY:**

Walks independently  Crutches  Walker  Manual Wheelchair  Power Wheelchair

Walks with frequent falls

Can the camper independently use his/her wheelchair?  Yes  No

List any other mobility needs or devices: \_\_\_\_\_

List make & model of any equipment: \_\_\_\_\_

**VISION:**

Normal  Partial  Legally Blind  Total Vision Loss

Camper wears (check all that apply):  Glasses  Contacts Please describe: \_\_\_\_\_

**TOILETING:**

No assistance  Partial Assistance  Total Assistance

Bladder Control:  Normal  Partial  Incontinent  Bed wetter  Needs Reminders

Bowel Control:  Normal  Partial  Incontinent  Needs Reminders

Aids used (check all that apply):  None  Urinal  Catheter Type: \_\_\_\_\_

Toilet Chair  Diapers  Ostomy (colostomy)  Urostomy  Ileostomy

Bed Pan  Laxatives  Enema  Suppositories  Other: \_\_\_\_\_

List toileting/catheter schedule: \_\_\_\_\_

**WASHING/BATHING:**

No assistance  Partial Assistance  Total Assistance

Prefers:  Shower  Tub Bath  Sponge Bath

**DRESSING:**

No assistance  Partial Assistance  Total Assistance

**SLEEPING:**

Sleepwalks:  Yes  No Need to awaken or turn during the night?  Yes  No

\*\*\*\*\*CAN CAMPER SLEEP ON AN UPPER BUNK? \*\*\*\*\*  Yes  No

**BEHAVIOR MANAGEMENT:**

List any specific problems or concerns: \_\_\_\_\_

Behavior modification techniques used: \_\_\_\_\_

**MEDICATIONS: Please list all medications, purpose and dosages of each medication and times each should be taken. \*The camp nurse will deliver routine prescription medications on the following schedule: 8a, 12n, 6p, 8p. Please call the camp director prior to camp for any special needs or concerns...251-479-4900.**

Name of medication	Purpose of medication	Dosage	Times to be taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List any other medications on a separate sheet of paper and attach with this application.**

\* Please note: Campers are expected to bring sufficient supplies of their medication(s), properly identified, with complete directions for usage. Send enough for the camper's entire stay plus several extras. Remaining medication will be returned. ALL medications must be sent in current prescription bottles. Over-the-counter medications must be in original bottles.

**REGISTRATION INFORMATION:**

A \$35 registration fee is required for each camper. This fee should be sent in with completed application. Applications will not be processed without the registration fee.

**SINGLE CAMPER FEE:** For one week session- \$325(includes reg. fee)

**MULTIPLE CAMPER FEE:** For one week session- \$275each (includes reg. fee)

*This discount is given only to FAMILIES sending more than one child and only applies if you pay for all children- EXCLUDES CAMPERSHIPS*

**After paying registration, the remaining \$290 for one child or \$240 for more than one child is due on or before JUNE 1<sup>st</sup>. Please call in advance if you need to make payment arrangements.**

THE NUMBER OF CAMPERS WE CAN ACCEPT IS LIMITED. IF YOUR CAMPER CANNOT ATTEND, PLEASE NOTIFY US AS SOON AS POSSIBLE SO THAT WE MAY ALLOW SOMEONE ELSE THE OPPORTUNITY TO ATTEND CAMP.

**REFUND POLICY:**

All fees will be refunded when notification of cancellation is received in writing **twenty-one (21) days** prior to the beginning of the camp session that camper has applied for.

**Income Information:**

**YOU MUST COMPLETE THIS SECTION IF YOU ARE INTERESTED IN REQUESTING A CAMPERSHIP.**

All financial information is for the use of Camp SMILE only and will be held in the strictest confidence.

Number of people in household: \_\_\_\_\_

Total household **monthly** income: \$\_\_\_\_\_

Sources of Income: \_\_\_\_\_

**Campership Requested:** \_\_\_\_\_ \$145 partial \_\_\_\_\_ \$290 full

Camperships are based on financial need and are awarded on a first come, first serve basis.

**APPLICATION DEADLINE**

The deadline for receiving applications is **April 1st**. Applications received after **April 1st** will only be considered if vacancies are available. Each application will be considered for acceptance on an individual basis. However, no applications received after **April 1<sup>st</sup>** will be awarded a campership, regardless of financial need.

I hereby apply for enrollment of my child in Camp SMILE provided by United Cerebral Palsy of Mobile, Inc. As a condition of such enrollment, I hereby represent to United Cerebral Palsy of Mobile, Inc. on behalf of myself and my child, my agreement with the general terms and conditions as follows:

\_\_\_\_\_ (initial) **Understanding of Risks:** I am aware that some camp activities, whether it be swimming, horseback riding, or any other associated activities, involve inherent risks and dangers to the participant, including serious injury or death.

\_\_\_\_\_ (initial) **Release of Liability:** I release United Cerebral Palsy of Mobile, Inc., property owners, their owners, agents, employees, successors of assigns, lessors and joint ventures from any and all liability, claims, demands, actions, causes of action, expenses and damages in any way resulting from personal injuries, conscious suffering, death or property damage sustained by my child or others arising out of my child's participation in camp activities. I hereby expressly waive all claims that I may have against UNITED CEREBRAL PALSY OF MOBILE INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES for each and all the foregoing.

\_\_\_\_\_ (initial) **Indemnity:** My child will exert every effort to follow the rules and instruction he/she has received prior to or during camp activities. I hereby agree for my child, myself, my heirs, personal representatives and assigns to indemnify, defend and hold harmless UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES from and against any and all losses, claims, demands, actions or proceedings of any kind which may be initiated against any of the foregoing by any person and arising out of any action or inaction on my part or the part of United Cerebral Palsy of Mobile, Inc., or its owners, agents, employees, successors or assigns and in any way related to any of the activities described in the preceding paragraph or contemplated under this agreement.

\_\_\_\_\_ (initial) **Continuation of Terms:** I agree and acknowledge that the terms and conditions of this Agreement, including my assumption of risk (paragraph 1), release of liability (paragraph 2), and indemnity (paragraph 3) shall continue in full force and effect at all times during which my child is engaged as a participant at Camp, shall continue in full force and effect for the benefit of UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR THE BUSINESS LAND OWNERS, PARTNERS, AGENTS, ATTORNEYS, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES at all times after the termination of the activities contemplated by this agreement and shall be binding upon my heirs, personal representatives and the assigns of my estate.

\_\_\_\_\_ (initial) **Disputes:** This agreement shall be interpreted in accordance with the laws of the State of Alabama. Any dispute shall be litigated in Mobile County Alabama.

\_\_\_\_\_ (initial) **Medical Release:** I hereby grant to the Camp Physician or his authorized representatives permission to furnish or arrange the furnishing of such hospital and medical care as named above camper MIGHT REQUIRE DURING SUCH TIME AS HE/SHE IS A CAMPER AT CAMP SMILE. This medical care shall include, but not be limited to, examinations, treatment, immunizations, injections, anesthesia, surgery and other procedures, etc. I understand that I shall be notified as soon as possible. Failure in such efforts shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of said camper.

\_\_\_\_\_ (initial) **Media Release:** I further grant permission for above named camper to be photographed, with such pictures and names to be used in public relations and fund raising efforts to promote programs of Camp Smile.

**I AM THE PARENT OR LEGAL GUARDIAN OF THE PARTICPANT, \_\_\_\_\_ . I HAVE READ AND UNDERSTAND ALL OF THE TERMS OF THIS AGREEMENT, INCLUDING THE "GENERAL TERMS" ABOVE. TO INDUCE UNITED CEREBRAL PALSY OF MOBILE INC. TO ENROLL THE PARTICIPANT IN CAMP AND TO ALLOW HIM/HER TO PARTICIPATE IN ALL CAMP ACTIVITIES. I AGREE ON BEHALF OF THE PARTICIPANT AND MYSELF TO BE BOUND BY THE GENERAL TERMS OF THIS AGREEMENT AND NOT TO CLAIM NOT TO BE BOUND BY THIS AGREEMENT BY REASON OF MY CHILD'S MINORITY STATUS OR OTHERWISE, I HEREBY AGREE TO INDEMNITY, DEFEND AND HOLD HARMLESS UNITED CEREBRAL PALSY OF MOBILE, INC., PROPERTY AND/OR BUSINESS OWNERS, PARTNERS, AGENTS, ATTORNEY, EMPLOYEES, SUCCESSORS, ASSIGNS AND/OR REPRESENTATIVES FROM AND AGAINST ANY AND ALL LIABILITY OR LOSSES RESULTING FROM ANY SUIT AGAINST UNITED CEREBRAL PALSY OF MOBILE, INC. BY THE PARTICIPANT OR OTHERWISE RESULTING FROM A BREACH OF AGREEMENT.**

\_\_\_\_\_ Date Parent/Guardian

\_\_\_\_\_ Date Witness