2023 Information Form

Please keep a copy of this form for your records

PARTICIPANT INFORMATION UPDATES			
Name:			
Address:			
City, St, Zip:			
Phone (daytime):		E-Mail:	
DOB:	Age:	NEGATIVE TB test copy submitted	
Diagnosis:		School:	
Takes Medication at Program? Yes No Has an Epi Pen Yes No		T-shirt ADULT: S M L XL XXL XXXL	

Same as participant	PARENT/GUARDIAN INFO	CASE MANAGER/FUNDER
Name		
Address		
City		
Home Phone #		
Cell #		
E-mail		

I understand illegal drugs, tobacco products, alcohol products or any weapons or explosives are not allowed while at program. I also agree that my camper will not steal, harm, destroy other's property, engage in sexual activity, fight or cause physical harm, use bad language or show disrespect to other campers or camp staff. Participation in such activities or the threat of such activity can result in removal of camp privileges and/or removal from camp including up to 1 week removed from program. Please initial ___________

IN CASE OF MEDICAL EMERGENCY, I understand that first aid will be available at camp and the camper will be closely supervised. If serious injury or illness develops, medical and/or hospital care will be given. I further understand that I will be notified in case of serious injury or illness; however, if it is impossible to contact me, I give permission to the physician selected by the camp to hospitalize, secure proper treatment and to order injection, anesthesia or surgery for the camper named above. Initial ___________

Froedtert **Aurora**

Photo Release: I do hereby consent and agree to allow the RecPlex to use my camper's image or likeness in photos, videos, or audio for educational or promotional purposes, including posting on the internet. I agree that the use herein is done so without compensation. Please initial ___________ I DO NOT grant permission to take photos of my camper ___________

Field Trip: I DO authorize my camper to travel to and from program events via program transportation. Please initial ___________

I DO NOT authorize my camper to travel offsite for program events or field trips: Please initial ___________

ITEMS REQUIRED AT REGISTRATION:

1. Information form - 2023
2. Medical release – valid for 1 year
3. TB test results, must be negative – required before starting program
4. Paid registration fee – FREE if a RP member, otherwise $75 for Spring, $75 for Summer, $75 for Fall
5. Dates of Attendance form – **SUMMER 2023**

ATTENDANCE EXPECTATIONS:

Each client will submit a schedule of dates of attendance for each semester they are attending with dates and times of attendance marked and anticipated times of arrival and departure. Clients will attend a minimum of 3 days per week and up to 5 days per week. Program hours will be from 9a -3p with respite available between 7a -9a and also 3p -5p. Attendance will be billed at a minimum of 3 days per week and 6 hours per day. Any schedule changes should be sent in writing (e-mail or written note) so that it can be shared with the group.

If not attending on a scheduled day, the parent or guardian is expected to alert the staff of non-attendance no later than 9am. Any changes to arrival or departure, including pick up person, mode of transportation, pick up or drop off time should be kept to a minimum. If a client has not arrived during their scheduled time, contact with the parent or guardian will be made.

BEHAVIOR GUIDELINES/EXPECTATIONS: Safety of all our participants and staff is our first concern. Our camp is set up to support campers who may need assistance in participating. We do not condone aggression towards other campers or staff. Our ratio is 4:1, therefore this camp may not be appropriate for every camper. Please keep that in mind when choosing the summer camp for your camper.

1. Keep your hands to yourself.
2. Show appropriate social behavior with peers & staff. (No spitting, hitting, kicking, scratching, pinching, etc)
3. Use appropriate language. (no swearing, yelling at others)
4. Respect your friends, your staff and yourself!
5. Participate in activities and have fun.
6. Please do not send toys or other valuables from home. We are not responsible for lost items.

Clients who have difficulty following the rules will be warned about their behavior. Clients who are physical or aggressive towards other campers or staff will be sent home for the first occurrence with the next day at home, out for a week for the second occurrence and removed completely for the third occurrence. We reserve the right to remove a client at any time if deemed a danger to self or others.

Permission Form/Waiver

As parent/guardian, I fully recognize and understand there are certain injury risks associated with being in a camp environment and that there is a risk of being injured while participating in camp activities such as swimming, ice skating, boating, off camp excursions. I recognize the risks involved and give permission for the camper listed above to participate in all camp activities unless otherwise noted in writing or restricted by the camper's physician on the medical release. In consideration of the privilege of camp attendance, it is expressly agreed that all use of services and facilities shall be undertaken at the participant's sole risk and that the RecPlex/Village of Pleasant Prairie shall not be held liable for any claims, demands, injuries, damages, or cause of action to any camper in conjunction with participation of camp. Further, the camp, camp staff, agents will not be held liable for loss of personal property of the camper.

Parent/Guardian Signature ______________________________ Date ____________________

HEALTH INFORAMTION & BACKGROUND

Disability(s): ______________________________ ______________________________

Check or list any condition a staff member should know about:

Heart Condition ___
Diabetic ___
Allergic to bee stings ___
Allergic to medication ___
Allergic to latex ___

Seizures ___
Eye Infections ___
Glasses/contacts ___
Headaches ___
Dietary restrictions ___

ALLERGIES:
Food Allergies: ______________________
Medication Allergies: ______________________
____
____

	MOBILITY		ATTENTION		TOILETING*
	Ambulatory		Typical Attention span		Toilets independently
	Uses Wheelchair		Needs transition assistance		Needs prompting/reminders
	Wears braces		Runs/Wanders		Needs assistance/supervision
	Needs assistance walking/stairs		Is easily distracted		Needs assistance with wiping
	Needs assistance in pool		Needs to be active		Uses toilet schedule (please supply)
	Needs assistance in bathroom		Needs frequent rests		Uses briefs (please supply 1 week at a time)

Food Allergy ___
Participation limits ___ ______________________
Other ______________________
Record of immunizations and date of last tetanus shot: ________

*We have both female and male staff. We typically have the same gender staff assist with toileting but if needed, an opposite gender staff may assist with toileting.

	PERSONAL CARE		MEALS		COMMUNICATION
	Can dress independently		Able eater		Communicates verbally
	Needs some assistance		Needs some help/prompting		Uses communication aid
	Needs complete assistance		Drinks with a straw		Uses sign language
	Needs help with shoes/tying		Takes food from others		Needs 1-2 step directions
	Needs help with shower/soap		Uses special utensils (please label)		Unable to communicate needs
	Needs help with deodorant		Difficulty chewing/swallowing		Non-verbal but can make needs known

* If g-tube fed, please attach a written feeding schedule including times and amounts.
* Any medically prescribed meals we should know about or food restrictions?

	BEHAVIOR & SAFETY	
	Best way to transition	
	Best way to redirect	
	Best way to calm	
	Behaviors when upset	
	Fears/triggers/phobias	
	Behavior Plan YES NO	If yes, please provide behavior plan.

Please list if there are any activities specifically not liked/enjoyed. ______________________
____

Other information not asked but we should know ______________________
____

☐ NO behavior concerns

	Behavior Concerns				
	Is self-abusive		Runs away/wanders		
	Abusive towards others		Difficulty with transitions		
	Bites (self or others)		Does not like loud noises		
	Scratches/pinches self or others		Does not like to be touched		
	Grabs others		Enjoys social time		
	Uses inappropriate language		Prefers activities alone		
	Uses inappropriate touch		Inappropriate sexual behavior		

Please do not be offended if we ask for photo identification from you or others who pick-up your child.
This is for the safety of all participants in our care.

Emergency Contact – people authorized to pick up your loved one, within 20 minutes of RecPlex
(Parents are always authorized to pick up, but we may ask for ID until all staff are familiar.)

Name	Relationship	Daytime Phone Number

The following are NOT authorized to pick-up my child:

Name	Relationship	Daytime Phone Number

GOALS: Please list 1-3 goals that can be worked on during the year.

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

THERAPEUTIC RECREATION DEPARTMENT
AUTOMATIC PAYMENT FORM

Please fill out completely to avoid delays in reserving space!

Client's Full Name:	Program (Check One): ☐ Discovery Adult ☐ Trekker Youth
Client's Full Name:	Program (Check One): ☐ Discovery Adult ☐ Trekker Youth
Client's Full Name:	Program (Check One): ☐ Discovery Adult ☐ Trekker Youth
Parent/Guardian Name:	Email Address:

PLEASE SELECT ONE OF THE OPTIONS BELOW.
(Restrictions apply to each option.)

☐ **OPTION 1:** Automatic Check Withdrawal Weekly - Attach a voided check to this form.

Bank Name:	Account Number:	Routing Number:

☐ **OPTION 2:** Payment by Automatic Credit/Debit Card Weekly (Enter card information and sign below).

Cardholders Name:	C.C. Financial Institution (bank name on credit card):

Card Type (check one): ☐ VISA ☐ MASTERCARD ☐ DISCOVER	Card Number:	Exp. Date:

Billing Address:

I hereby authorize the RecPlex and the financial institution designated above to begin automatic deductions from the account designated above for all program participants listed on this form. I understand my checking account or credit card will be charged weekly. I understand that my monthly checking account or credit card statement will typically show the amount and the date payment was made to the RecPlex. I understand that I am responsible for ensuring that the account designated above has sufficient funds on a weekly basis to allow for the automatic deduction of my payment. I understand that if there are any changes to my account I must notify the TR/Billing Department in writing 7-10 days prior to my scheduled weekly automatic payment deduction. I understand I am liable for any uncollected payment and for any fees or penalties imposed by the RecPlex or my financial institution related to any uncollected payment. I am the parent/guardian and agree to the terms of this document.

By signing below, you understand and agree to the terms, policies and guidelines set forth by the RecPlex. You are responsible for all costs incurred with collecting debts more than 30 days past due, including but not limited to, fees for late payments, uncollected payments, filing fees, court costs, and attorney's fees.

- Each returned or uncollected balance will incur a $35.00 reversal fee.
- Unpaid balances will result in denial of service or care provided.
- By providing a credit or checking account on file, you are authorizing the RecPlex to charge any out of pocket expenses you are signing your participant up for including but not limited to: care, clubs, field trips, programs, additional days of care, etc.

If funded:

- Service authorizations must be current and outline all services covered by the funder and it is the responsibility of parent or guardian to communicate with their case managers/funders.
- Any services not covered by the funder are the financial responsibility of parent/guardian and will be billed to the payment method provided.
- I understand it is my responsibility as parent/guardian to communicate my service needs to my funder/case manager.
- THE RECPLEX WILL NOT BE CONTACTING ANY FUNDER TO ADD, DELETE, OR ADJUST ANY SERVICE AUTHORIZATIONS.

Account Holder Signature:	Date:

Third Party Billing – ADULT SUMMER 2023 **Client Name:** ______________________________

Funder Contact & Number: __________________________

Third party clients must have an authorization or proof of funding prior to registering for the SPRING session. This documentation can be sent via e-mail to ewinch@plprairiewi.com. We require either 3, 4 or 5 full days per week. Program hours are from 9a -3p. AM Respite hours are 7 -9am and 3-5pm. Please include your student's arrival time and your departure times so that we can adequately staff for your times of attendance. Respite hours must be scheduled prior to use. Late pickups are not allowed. Our goal is to cut down on the number of schedule changes in attendance each week. Thank you for your assistance.

	AM RESPITE	PM RESPITE	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week 0: June 5 - 9			Camp soft start					Respite
Week 1: June 12-16			1st day CAMP					Respite
Week 2: June 19-23								Respite
Week 3: June 26-30								NO RESPITE
Week 4: July 3 -7								Respite
Week 5: July 10-14								Respite
Week 6: July 17-21								Respite
Week 7: July 24-28								Respite
Week 8: July 31 – Aug 4								Respite
Week 9: August 7-11								Respite
Week 10: August 14-18								Respite
Week 11: August 21-25								Respite
Week 12: August 28 - Sept1							Last day of camp	NO RESPITE

Summer camp will officially start on Monday, June 12th, earlier start dates available upon request and in order of request. All paperwork, forms and authorizations must be submitted prior to start of program. Summer camp registration will be allowed once all completed paperwork is submitted and confirmed by the billing department. Registration is not complete until all pieces of required paperwork are submitted.

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-20810 (Rev. 08/2008)

STATE OF WISCONSIN

MEDICAID WAIVER PROGRAM HEALTH REPORT

Use of form: Personally identifiable information collected on this form is confidential and will be used for identification purposes and to document the individual's health information necessary in determining eligibility for services. Completion of this form is necessary to meet the requirements of Wis. Stats. 46.27(11) and 46.277(4).

Instructions: Complete within 90 days (before or after) the Waiver Start Date and annually within 90 days (before or after) the Waiver recertification month for each CIP II or COP-W participant.

A. TO BE COMPLETED BY CARE MANAGER

Name – Participant (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Name – County Agency / Care Manager	
Name – Physician / Clinic / Office	Physician's Telephone Number

B. TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE

1. Describe participant's diagnosis (i.e., disabilities / impairments / rehabilitation potential / prognosis). List primary diagnosis first. If necessary, attach additional documentation.)

1a. Condition is considered: ☐ Stable ☐ Unstable (Check one.)

2. List name of medications, dosage and frequency. Include injections, prescription and over-the-counter medications ordered. If necessary, attach additional documentation.

2a. ☐ Yes ☐ No Medications should be supervised. (Check one.)

3. Physician's Orders

a. Therapies / home health (Check all that apply.)

☐ Home nursing care
☐ Occupational therapy
☐ Physical therapy
☐ Home health aide
☐ Speech therapy
☐ Assistance with housekeeping / chores
☐ Personal care
☐ Other

b. Treatments

☐ Oxygen
☐ Dialysis
☐ IV meds
☐ Decubiti care
☐ Ventilator
☐ Ostomy care
☐ Suctioning
☐ Transfusions
☐ Chemotherapy
☐ Catheter – Type: ____________________
☐ Feeding tube
☐ Parenteral / IV
☐ Severe pain
☐ Radiation
☐ Range of motion
☐ Other – List below.
____
____
____

4. Ongoing diagnostic tests required – type and frequency	5. Diet / nutrition – List special instructions

SIGNATURE – Physician, Physician Assistant or Registered Nurse	Date Signed

CARE MANAGER – See page 2

C. COMPLETION OF ITEMS 1 AND 2 BELOW ARE OPTIONAL.

If part C is completed, the information should be provided by the care manager, nurse or another professional familiar with this applicant / participant. Enter information not found on the Long Term Care Functional Screen or the Assessment / Supplement, or that is missing from page one of this form.

1. Describe mobility / activity limitations. List DME or adaptive aids needed.

2. Other relevant information: Mental status, orientation, communication, social abilities, special health needs or other applicant / participant-specific information that substantiates the level of care determination.

Name – Person filling out part C	Title

SEIZURE ACTION PLAN

Effective Date: ______________________

This child is being treated for a seizure disorder. This information below should assist you if a seizure occurs during childcare hours.

Child's Name	Date of Birth	
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	
Significant Medical History		

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Child response after a seizure:

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

Does the child need to leave the other children to recover? ☐ Yes ☐ No

If YES, describe process for returning child to interact with others:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this child is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ☐ Call 911 for transport to ______________________
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other ______________________

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic)seizure lasts longer than 5 minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child has a first-time seizure
- Child has breathing difficulties
- Child has a seizure in water

Treatment Protocol During Childcare Hours (include daily and emergency medications)

Emerg. Med.	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does child have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature ______________________ **Date** ____________

Parent/Guardian Signature ______________________ **Date** ____________

Date Rcvd: ____________
Date to begin: ____________
Date to end: ____________
Initials: ____________

TR Transportation Services

Information about person needing transportation:

Last Name: ______________________ First Name: ______________________

Address: ______________________ Apt #: ____________

City: ______________ State: __________ Zip Code: ____________

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________ E-mail: ______________

Emergency Contact other than home within in 30 miles: ______________________
Name Phone Number

Special Handling – Check all that apply:

___ Wheelchair ___ Physical Disability ___ Behavior ___ Visually Impaired

___ Harness ___ Hearing Impaired ___ Seizures Other ____________

Transportation Schedule Information: Please allow a minimum of 1 week for processing:

Requested start date for transportation: ______________________
Month Day Year

Requested end date for transportation: ______________________
Month Day Year

Days requested for transportation: Monday Tuesday Wednesday Thursday Friday Saturday

Transportation Schedule:

Morning route? YES or NO
Pick up time at home: ____________ AM or PM

Afternoon route? YES or NO
Pick up time at RecPlex: ____________ AM or PM

Please also read and sign on the back for agreement of services.

TR Transportation Services

Transportation Policies

1. Pick up and drop off times are approximate. Drivers may come 10-15 minutes early or late depending on other riders.
2. Services are available for WI riders in Kenosha/Pleasant Prairie area. Other riders can contact Southport Transportation 262-564-8354, K-Town 262-764-0377 or Care A Van 262-658-9093.
3. Schedule changes of ½ hour or more will be called to families with riders on the bus.
4. Weather and traffic are factors. If road conditions are poor, it may take longer to get everyone to their location safely or we may depart early to get ahead of an incoming storm. Severe weather conditions can result in transportation will be canceled for the day. This includes both AM and PM routes. Notice of the cancelation will be posted on our Facebook page or you can call the main line at 262-947-0437.
5. Riders must be picked up or dropped off at the same location each day. We are unable to change pick up or drop off locations.
6. Clients must be picked up or dropped off to a responsible adult over the age of 18.
7. If your student is going to be absent, please notify our office at least 24 hours in advance or once you know your student is not attending. That number is 262-947-3660. If there will be a change in ridership, we require 1 week prior notice.
8. Repeated failure to notify that a student is not being transported can result in termination of services. A one week notice of termination of service will be given to arrange alternate transportation arrangements.
9. Riders must wear safety belts at all times.

Our rules and guidelines are in place for the safety of our drivers and all our riders. We reserve the right to remove a rider or discontinue service if they are deemed a risk to self or others or there is repeated transportation concerns. By signing below I acknowledge that I have read and understood the policies for transportation of my student.

______________________________ ____________________

Parent/Guardian Signature Date