

## Camp Kaos 2012 Camper Registration, Information & Waiver Form

Please return completed Registration, Information & Waiver Form to:

**United Cerebral Palsy of the North Bay**  
**Attn: Ann Elias**  
**3835 Cypress Drive, Suite 103**  
**Petaluma, CA 94954**

***PLEASE NOTE:** Space may be limited and will be available on a first-come, first-serve basis.*

**COST: \$180.00**

**Make checks payable to:** UCPNB (payable on or before the first day of camp)

Name of Child: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Case Manager (if being funded by Regional Center): \_\_\_\_\_

If you have any questions, please email Ann Elias [aelias@ucpnb.org](mailto:aelias@ucpnb.org).

*Play without limits for people with disabilities*

## Camper Information

The following questions will assist camp staff in determining the appropriateness of the camp for your child and in accommodating the needs of your child during camp.

1. What is your son/daughter's disability and what do we need to know in order to safely and successfully work with him/her in an activity setting? Any activity limitations?	
2. Does your son/daughter require 1:1 supervision? (i.e., constant supervision to assure safety of him/herself or others)  • If yes, please describe.	Yes ____ No ____
3. Does he/she need help eating?  • If yes, please describe.	Yes ____ No ____
4. Is he/she toilet trained?  • What assistance is needed? (e.g., snaps, buttons, undressing/dressing, wiping, etc.)	Yes ____ No ____
5. Has he/she ever been separated from the family before?  • Please describe.	Yes ____ No ____
6. Are there any precautions you wish to have observed at camp?  • Please describe.	Yes ____ No ____
7. What are his/her favorite activities? Hobbies? Interests?	
8. Does he/she have behaviors that could result in harm to self or others?  • Please describe. (Please note: if these behaviors occur at camp, he/she may be sent home.)	Yes ____ No ____
9. What HEALTH PRECAUTIONS, ALLERGIES, SPECIAL INSTRUCTIONS, RESTRICTIONS, BEHAVIORS, OR MEDICATIONS, etc., do we need to know about? Any effective strategies or procedures that would be helpful?	

**Use additional pages if necessary.**

## Camp Kaos Camper Waiver-Release Form

**Child's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Photographic Release**

I/We (Initial) \_\_\_\_\_ hereby give consent / do not (Initial) \_\_\_\_\_ give consent to United Cerebral Palsy of the North Bay (UCPNB) photograph our **child/self (name)** to educate others about the programs and services offered by UCPNB. Among the uses contemplated are illustration of articles in newsletters, in profiles that contributors receive, in brochures, to illustrate services discussed on the web site, in displays at community fairs, to publicize local programs, to make professional presentations, to conduct research on teaching techniques and equipment used at the camp, and to publicize the equipment and teaching methods used. In giving approval, I/we understand it is without consideration of compensation of any kind, and UCPNB is released from any claims or liability. If wider use is contemplated, UCPNB will get separate approval.

**Medical Release**

In the event that an emergency requiring medical or surgical care or treatment should arise while (**Child's Name**),

\_\_\_\_\_ is attending the UCPNB program, and I /We ARE NOT PRESENT TO MAKE MEDICAL DECISIONS, I/We (Initial) \_\_\_\_\_, authorize/do not (Initial) \_\_\_\_\_ authorize the said UCPNB to select and designate nurses, physicians, emergency medical staff (EMS) and surgeons to furnish such medical and/or surgical care as, in the judgment of a physician and/or surgeon holding a physician's certificate issued by the Board of Medical Examiners of the State of California may be needful and proper. I/We absolve UCPNB and nurses, physicians, EMS personnel, and surgeons selected and designated by them, from any and all liability for their acts rendered in good faith.

Family Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance Co. & Plan No.: \_\_\_\_\_

**Personal Property**

I/We (Initial) \_\_\_\_\_, recognize that UCPNB cannot accept responsibility for child's personal property. To help eliminate losses, please tag name inside equipment, clothes or other personal items.

**Parents:**

(Both parents required)

**If Separated or Divorced:**

(Signature of Party with Legal Custody)

\_\_\_\_\_  
Mother Date

\_\_\_\_\_  
Mother Date

\_\_\_\_\_  
Father Date

\_\_\_\_\_  
Father Date

**Guardian(s):**

**Child:** If responsible for his/her own legal affairs

\_\_\_\_\_  
Guardian Date

\_\_\_\_\_  
Child Date