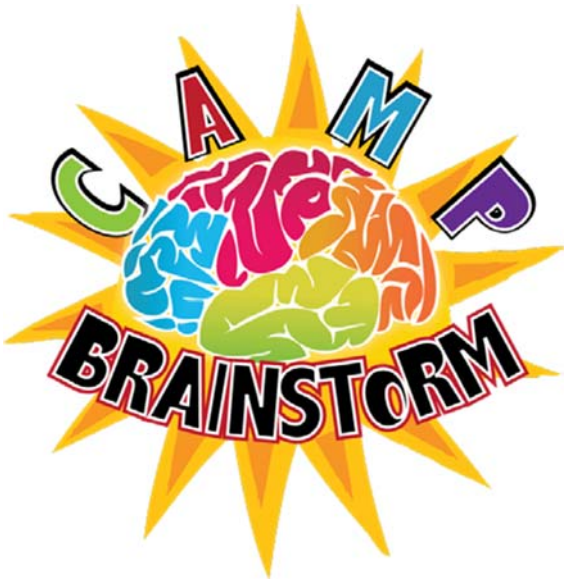

Monday June 17 – Friday June 21, 2019

PART 2: CAMPER APPLICATION PACKET

APPLICATION DEADLINE: April 15, 2019

(Print, Complete, Sign & Return by mail, fax, email or drop off)

Epilepsy Foundation Central & South Texas
8601 Village Drive Ste 220
San Antonio, TX 78217
(210) 653-5353 | Fax: (210) 653-5355
Email: camp@efcst.org
www.efcst.org

EPILEPSY FOUNDATION
Central & South Texas

PART F: CAMP BRAINSTORM CONSENT

Please read and initial to confirm that you have read each section.
Incomplete consent forms may cause a delayed or rejected application.

Name of Camper *(print)*: _____

I. **PARTICIPATION CONSENT:** ***My signature below gives my consent for my child to participate in Camp activities at Camp Brainstorm.*** I understand and certify that my child,_____, may participate in Camp Brainstorm and its activities at Camp Aranzazu, and that his/her participation is completely voluntary. I have familiarized myself with the programs and activities at Camp Brainstorm in which my child will participate. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not be limited to, the activities of horseback riding, high and low elements rope course, swimming, archery, canoeing and team sports such as soccer. I acknowledge that although the Epilepsy Foundation Central & South Texas (EFCST) and Camp Aranzazu have taken safety measures to minimize the risk of injury to camp participants, EFCST and Camp Aranzazu cannot ensure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I understand that under Texas Law, an equine professional is not liable for an injury or death of a participant in equine activities resulting from the inherent risks of equine activities. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations and procedures for Camp Brainstorm. I have received approval from a doctor authorizing my child to participate in Camp Brainstorm and its activities at Camp Brainstorm and Camp Aranzazu. _____ *(initial)*

II. **PERMISSION FOR TREATMENT & TRANSPORT:** ***My signature below gives my consent for my child to treated and transported.*** The health history described in the Camp Brainstorm Camper Information and Health History Form is correct to the best of my knowledge. In the event of an accident or injury involving my child,_____, I authorize the Camp Brainstorm and/or Camp Aranzazu directors, counselors, program staff, medical staff, volunteers or other executors to obtain medical treatment for my child and to transport if needed. I give permission to the physician selected by EFCST to order x-rays, routine tests, and treatments; and, in the event of any perceived emergency, I give permission to the physician selected by EFCST to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. I understand that payment of any medical expenses incurred by my child will be my responsibility._____*(initial)*

III. **LIABILITY RELEASE:** ***My signature below releases the Epilepsy Foundation Central & South Texas (EFCST) and/or the Camp Aranzazu from any and all liabilities.*** I, the undersigned, understand that occasionally accidents occur during camp activities, and that participants may sustain serious personal injury and property damage as a consequence thereof. Knowing the risks of camp activities, I nevertheless agree to assume those risks. By signing this liability release, I intend to legally bind myself, my minor children, my heirs, executors and administrators, and anyone claiming by, through or under any of them. I HEREBY RELEASE AND FOREVER DISCHARGE THE EPILEPSY FOUNDATION CENTRAL & SOUTH TEXAS AND CAMP ARANZAZU, AND EACH OF THEIR OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS (THE "RELEASED PARTIES") FROM ALL CLAIMS, CAUSES OF ACTION OR DAMAGES ARISING OUT OF ANY INJURY, ILLNESS, OR LOSS OF ANY KIND, THAT MAY BE SUSTAINED BY MY CHILD DURING OR RELATED TO MY CHILD'S ATTENDANCE AT CAMP BRAINSTORM AT CAMP ARANZAZU, WITHOUT REGARD TO THE CAUSE OR CAUSES OF SUCH INJURY, ILLNESS, OR LOSS, EVEN IF SUCH CLAIMS, CAUSES OR ACTION, OR DAMAGES ARISE FROM THE NEGLIGENCE OR CARELESSNESS OF THE RELEASED PARTIES.
_____ *(initial)*

IV. **MEDIA RELEASE:** I hereby give the Epilepsy Foundation/Epilepsy Foundation Central & South Texas (EFCST) and Camp Aranzazu the right to interview and/or take photographs, audio, or audio-visual recordings of my child,_____, which may be used in promotional, educational, or fundraising materials including, but not limited to videotapes, pamphlets, brochures, and their websites. The EFCST and Camp Aranzazu shall have the right to use photographs or other images of my child in promotional, educational, or fundraising materials. I hereby release the EFCST and Camp Aranzazu from any and all claims arising out of such photography, reproduction, publication or exhibition as is authorized by EFCST and/or Camp Aranzazu. I acknowledge that I have legal authority to sign this form on behalf of the above-mentioned child. Media release is required to attend Camp Brainstorm. _____ *(initial)*

V. **BRAINSTORM DIRECTORY: In order to foster new friendships made at camp, a directory (**addresses & phone numbers) will be compiled for Camp Brainstorm campers and counselors. Would you like for us to include your child's contact information?

- ☐ Yes, please give my address and phone number to my child's counselors and fellow campers.
- ☐ No, please keep my address and phone number confidential.

The undersigned acknowledges and agrees to the rules and responsibilities set forth herein.

Printed Name	Signature of Parent/Legal Guardian	Date

PART H: CAMPER TREATMENT FORM

Camper's Name			
	Last	*First*	*Middle Initial*

Please list any food and/or drug allergies that your child has:

Please check which therapy your child is currently on: (check all that apply)

☐ Medications
☐ Vagus Nerve Stimulator
☐ Dietary Treatment - Please list type of diet _____
☐ Other (please list) _____

Special Instructions or Needs:

1. Is your child able to swallow pills: ☐ Yes ☐ No If No, describe how your child takes medications at home? _____

2. Are there any special instructions that the medical staff should be aware of concerning your child's medications? ☐ Yes ☐ No

   If YES, please explain _____

Consent to Administer Medications

*(Please initial **each** item to indicate authorization)*

_____ I authorize Camp Brainstorm medical staff to administer prescribed medications listed on the Medication Administration Form as indicated/ordered by the physician.

_____ I authorize Camp Brainstorm medical staff to administer emergency medications as ordered. If emergency medication is not provided, I authorize the Camp Brainstorm Neurologist to prescribe/dispense medications for the reduction of cluster/emergent seizures (parent/guardian will be contacted by phone prior to taking this action) or to transport to ER if necessary.

_____ I will update the Medication Administration Form that if medications are changed before camp.

_____ I will provide medications in the original pharmacy containers or bubble packed, with physician instructions on the label(s).

_____ I will provide medication in sufficient quantities for the number of days/nights of camp. I understand camp staff will be unable to refill medications.

_____ I authorize Camp Brainstorm medical staff to administer approved over the counter medications as needed during camp.

_____ I will provide over the counter medications with the instructions clearly labeled on the bottle (i.e. Children's Multivitamin, give one tablet once daily).

OVER THE COUNTER MEDICATIONS

The following over-the-counter (OTC) medications or topical treatments may be provided during Camp Brainstorm (dose dispensed as indicated for child's age/weight unless otherwise noted on Medication Administration Form):

Tylenol/Acetaminophen for pain, fever, headaches	☐ Yes	☐ No	Triple Antibiotic Ointment for cuts/ scrapes	☐ Yes	☐ No
Ibuprofen/Advil/Motrin for pain, fever, headaches	☐ Yes	☐ No	Hydrocortisone Cream for itching/bug bites	☐ Yes	☐ No
Tums/Antacids for upset stomach	☐ Yes	☐ No	Calamine Lotion for itching/bug bites	☐ Yes	☐ No
Claritin (Loratadine) for allergy symptoms	☐ Yes	☐ No	Topical Mosquito Spray	☐ Yes	☐ No
Zyrtec (Certirizine) for allergy symptoms	☐ Yes	☐ No	Topical Sunscreen	☐ Yes	☐ No

I hereby give my permission to Camp Brainstorm Medical Staff to administer prescribed and approved over the counter medications (selected above) to my child as indicated in the Consent to Administer Medications section above.

Parent/Guardian's Signature _____ Print Name _____ Date _____

PART I: MEDICATION ADMINISTRATION FORM

Camper's Name			
	Last	*First*	*Middle Initial*

MEDICATION LIST

Please include all medications - including as needed medications, over the counter medications, inhalers, and rescue medications (ie. diastat, epipen, nebulizer treatment)
Please copy this form should you need additional space.

Medication Name	Medication Strength (mg)	Route (Oral, Inhaled, Rectal)	Breakfast 8:00 – 9:00 am	Lunch 12:00 – 1:00 pm	Afternoon 3:00 – 4:00 pm	Dinner 6:00 – 7:00 pm	Night 9:00 – 10:00 pm
(Sample) Keppra	500mg per pill	Oral	2 pills (1000 mg)			2 pills (1000 mg)	

Parent Signature _____ Date _____

CAMP PHYSICAL EXAMINATION FORM

This Examination must be performed within 12 months of camp.

TO THE EXAMINING PROVIDER (M.D., D.O., P.A.-C, N.P.) You are being asked to certify that this individual has no contraindication for participation in a rigorous outdoor overnight camping experience.

Child Name:_____ Age:_____ Sex: ☐ Male ☐ Female

Height:_____ Weight:_____ Blood pressure:_____ Pulse: _____

	Normal	Abnormal	Explain Any Abnormalities
Eyes			
Ears			
Nose			
Throat			
Lungs			
Neurological			
Heart			
Abdomen			
Skin			
Extremities			
Emotional Adjustment			

Other	Yes	No
Contacts		
Dentures		
Braces		

Medical Equipment(CPAP, O^2, AFO):

Allergies:

Current Epilepsy Treatment: ☐ Medication ☐Vagus Nerve Stimulator ☐ Ketogenic Diet ☐ Other _____

Seizure Classification: Type #1:_____ Type #2: _____

Other chronic or recurring illnesses or physical limiting conditions: _____

Describe any behavior disturbance: _____

Special instructions/Comments/Limitations: _____

Does child have emergency medications prescribed for emergent seizures (clusters/prolonged seizures)? ☐ Yes ☐ No

List all medications child is currently taking:

Medication	Dose	Frequency

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in an overnight Outdoor Camping experience. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

_____ _____ _____

Examining Physician (Print) Signature Date

_____ _____ _____

Address City/State/Zip Phone Number

Return to: Camp Brainstorm Health Director
Epilepsy Foundation Central & South Texas | 8601 Village Dr Ste 220 | San Antonio, TX 78217
(210) 653-5353 | Fax: (210) 653-5355 | camp@efcst.org

EXHIBIT D
LIABILITY AND PHOTO RELEASE
DEMOGRAPHIC DATA COLLECTION

I, the undersigned, understand and acknowledge that occasionally accidents occur during camp or retreat activities and that participants may sustain serious personal injury and property damages as a consequence thereof. I understand that at Camp Aranzazu there are adventure sports including a ropes/challenge course, sailing, hiking, kayaking, archery range, and swimming pool. I understand that all activities are to be used only under direct camp supervision. I understand that Camp Aranzazu does not have a medical team on site. Knowing the risks of camp and retreat activities, nevertheless, I agree to assume those risks and by signing this liability release, I intend to legally bind myself, my minor children, my heirs, executors, and administrators. I hereby release and forever discharge Camp Aranzazu, and any of its assigns from all claims, causes of action or damages arising out of any injury, illness, or loss of any kind, known or unknown, including but not limited to injuries to property or person to me/my child during or related to my/my child's attendance at Camp Aranzazu.

I give permission and consent to allow photographs or video to be taken during camp session activities. I further give permission and consent that any such photographs or video may be published and used by Camp Aranzazu and the American Camp Association® and its agents, to illustrate and promote the camp experience, Camp Aranzazu and its camp programs, or the American Camp Association. _____yes _____no

The information below must be completely filled out and signed.

Camp/Group Name: _____ Date(s) of camp: _____

Attendee Name: _____ Date of Birth: _____

Attendee is coming to Camp Aranzazu as a: ☐ Camper ☐ To Volunteer With Attending Group
☐ Paid Staff for Group Attending ☐ Day Visitor Date: _____

Attendee or Parent/Guardian Signature: _____

Attendee or Parent/Guardian Name (Printed): _____

Relationship to Attendee: _____

Mailing Address: _____

City, ST ZIP: _____County:_____

Telephone: _____ Email: _____

☐ Check this box if you do not want your email address added to our mailing list.

Date: _____

We seek funding from the community to help underwrite the cost of camp. Most of our funders want to support kids in their community, especially those who are economically disadvantaged. Your willingness to provide the information below will help us keep camp affordable.

Ethnicity: ☐ Hispanic ☐ Anglo ☐ African American ☐ Asian ☐ Other Gender: ☐ Male ☐ Female

Household Income: ☐ Under $25,000 ☐ $25,000-$75,000 ☐ Over $75,000 # People in Home:_____

FOR OFFICE USE ONLY: ☐ Mission ☐ Non-Mission

Seton Healthcare Family

Consent and Release of Protected Health Information for Media/Public Relations, Fundraising and Marketing Purposes

I authorize Seton Healthcare Family and its related entities (including but not limited to hospitals, clinics, and physician offices) to take photographs, films, audio and/or video recordings of me, interview me, or publish article(s) or information about me and disclose to the public such protected health information related to the following purposes:

☒ Publications, fundraising, publicity, promotion, websites, social media, or advertising for Seton Healthcare Family or any of its related entities. Examples of social media include internet forums, blogs, social networking sites, podcasts and videos.

☒ Communication with media, including, but not limited to, newspapers, magazines, radio, television, film, and all types of electronic communication.

☒ Training materials, educational information or community programs for Seton and/or the general public.

Briefly describe nature of project, including a specific description of what health/personal information will be involved.

Seton staff will photograph and/or video tape activities and events at Camp Brainstorm.

I understand that I may be personally identified in any use of the above materials. I realize that this use is solely for the benefit of Seton and I will not receive any compensation. I understand that once my health information is used or disclosed, it is no longer protected by state or federal law. I have been informed that I can revoke this authorization at any time by submitting a written request to: Seton Healthcare Family, Attn: Communications/Media, 1345 Philomena St., Suite 300, Austin, TX 78723. I understand that if I do revoke this authorization, it will not have any effect on disclosures made prior to Seton receiving the revocation. I understand that Seton cannot make me sign this authorization as a condition for providing me treatment, making payments on any bills, or obtaining enrollment or eligibility in any health plan. This release will expire 10 years from the date signed below unless otherwise indicated.

I hereby transfer and grant Seton the exclusive right to own, use and authorize others to use all or any part of my information, interview/photograph/video for uses described above. I also hereby release Seton and its directors, its members, trustees, officers associates and agents from any and all claims, demands, causes of action and suits including, but not limited to, claims for invasion of privacy, defamation, breach of contract or other breach of duty arising out of or in connection with use or disclosure of my protected health information as described above. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility. I acknowledge that I have received a signed copy of this authorization.

Signature of Patient or Patient's Personal Representative	Date signed	Time

(Provide Relationship to Patient, if applicable)

Media Consent

Note to Staff: Authorization must be signed by the parent or legal guardian of any participant under 18 years of age, the legal guardian of any patient under guardianship. If the patient is under 18 years of age and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self.

A copy of this consent must be maintained in the patient's medical record.

The University of Texas at Austin
Release Form

I do hereby authorize The University of Texas, and those acting pursuant to its authority to:

a. Record my participation and appearance on video tape, audio tape, film, photograph or any other medium.
b. Use my name, likeness, voice and biographical material in connection with these recordings.
c. Exhibit or distribute such recording in whole or in part without restrictions or limitation for any educational or promotional purpose which The University of Texas, and those acting pursuant to its authority, deem appropriate.

Name: _____

Address: _____

Phone No. : _____

Signature: _____

Witness Signature: _____

Parent/Guardian Signature (if under 18): _____

University of Texas System Office of General Counsel
Comments to gharper@utsystem.edu

Last updated: June 24, 1999