Monday June 17 – Friday June 21, 2024

PART 2: CAMPER APPLICATION PACKET

APPLICATION DEADLINE: April 26, 2024

(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
Benadryl for severe 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)	Breakfast 8:00-8:30am	Lunch 12:00 pm	Afternoon 3:00pm	Dinner 6:00 pm	Evening 8:00-8:30pm	Bedtime 9:30-10:00pm
(Sample) Keppra	500mg per pill	Oral	2 pills (1000 mg)			2 pills (1000 mg)		

By signing I consent to medication administration by the medical staff at the Epilepsy Foundation Central & South Texas.

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. I also understand that there is some degree of risk of contracting a communicable disease at any camp, including Camp Aranzazu. 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, its officers, directors, agents, shareholders, and employees, holding all and each of them harmless from any and all claims, actions, suits, procedures, costs, expenses, damages and other liabilities including, but not limited to attorneys' fees, arising out of, connected with, or otherwise resulting from any injury or loss 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 also 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 their agents, or donors, to illustrate and promote the camp experience, Camp Aranzazu and its camp programs, or the American Camp Association.

☐ Check this box if you **do not** give permission and consent to allow photographs or video to be taken during camp.

The information below must be filled out completely and signed.

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

Attendee Name: _____ Date of Birth: _____

Attendee is coming to Camp as a: ☐ Camper ☐ Volunteer ☐ Paid Staff ☐ 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: _____

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

We use the information below to help us write grants to keep the cost of camp as low as possible.

Attendee qualifies for free or reduced lunch at school: ☐ Yes ☐ No ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latinx ☐ White ☐ Black/African American ☐ Asian
☐ Indigenous ☐ Other _____ ☐ Prefer not to answer

FOR OFFICE USE ONLY: ☐ Mission ☐ Non-Mission