Child's Name _____

Camp Prov 2023 Camper Registration Form

➔ (**EACH** child must have a separate form) ➔
- Please Write Neatly! –

The full tuition of Camp Prov is $130, which is a small percentage of the actual cost. Due to needing to restrict numbers of campers we will need to limit the ages of Campers this year. We will be accepting children ages 3-12, and siblings ages 3-9.

Child's Name **First** **Last**	Date of Birth:	Age on 7/1/22:

Name Child Goes By:	Siblings at Camp (First Last):

Child's Diagnosis:	Primary Language:

Street Address:	City, Zip Code:

Parent/Legal Guardian (First Last):	Relationship:

Primary Phone Number:	Email:

Please indicate which week & session you prefer by numbering your choices 1-4 **Sessions are filled on a first come, first served basis**		
July 10-14:	9am-12pm ☐	1pm-4pm ☐
July 17-21:	9am-12pm ☐	1pm-4pm ☐
July 24-28:	9am-12pm ☐	1pm-4pm ☐
July 31-August 4:	9am-12pm ☐	1pm-4pm ☐
August 7-11:	9am-12pm ☐	1pm-4pm ☐
Child's T-shirt size: ☐ X-Small ☐ Small ☐ Med. ☐ Large ☐ X-Large		

Completed Forms can be mailed to:	**Please make checks/money orders payable to:**
Providence Children's Center Camp Prov 900 Pacific Ave Suite 130, Everett WA 98201 -or- FAXED to 425.258.7618	Children's Center – Camp Prov ***Note***: We accept checks, credit / debit cards, but are unable to accept cash

Child's Name _____

Please Note: ***We are here to support your child the best way we can during their time at Camp Prov!***

Tell us about your child
What are his or her strengths and abilities?

What are his or her favorite toys and things to do?

What makes him or her a great kid?

What makes your child feel proud of them self?

Current Services
Does your child receive services at Providence Children's Center?
☐ Yes ☐ No

Hearing & Vision
How does your child hear and see?
☐ Typical Hearing ☐ Hearing loss
☐ Wears hearing aid/s ☐ Cochlear Implant
☐ Other _____
☐ Vision loss ☐ Wears glasses ☐ Uses a cane
☐ Other_____

Communication
How does your child communicate?
☐ Spoken words -- understandable to others? ☐ Yes ☐ No
☐ Sounds ☐ Signs ☐ Gestures ☐ Communication board, PECS
☐ Augmentative Communication Device: _____
☐ Sign Language
☐ Other:_____
If your child has a communication device, please plan on bringing it labeled with their name to camp and allow time on the first day to review with staff.
How will your child tell us he/she is:
Having a good time _____

Is sick or in pain _____

Anything else we should know about your child's **Communication**? _____

Child's Name _____

Swimming- NOTE: The swimming pool is closed
It is OK for my child to get wet in the waterpark: ☐ Yes ☐ No

Likes and Dislikes

My child tends **enjoy** the following:
☐ Tight spaces ☐ Brushing ☐ Squeezing ☐ Jumping
☐ Heavy lifting/carrying ☐ Swinging ☐ Spinning
☐ Other:_____

My child tends to **avoid** the following:
☐ Bath time/pool ☐ Loud noises ☐ Friend / Peer interaction
☐ Large groups ☐ Food ☐ Certain smells ☐ Animals
☐ Sitting at a table ☐ Getting hands dirty
☐ Other: _____

Behavior
Does your child have a behavior plan? (if yes, please attach it or a summary so we can follow it also)
☐ Yes ☐ No

What should we know about your child's behaviors? (such as going from one activity to another)

What do you do to calm and reassure your child?

*If your child has a comfort toy/object, please send it **labeled** with name in the child's backpack in the event we need it to help soothe.*

Does your child: (check all that apply)
☐ Run away ☐ Hit ☐ Kick ☐ Spit
☐ Bite/scratch/pinch / hit themselves ☐ Bite/scratch/pinch others
☐ Other: _____

Child's Name _____

Social and Home

What does your child typically enjoy doing:

☐ playing with a friend ☐ playing with several friends ☐ playing by themselves
☐ reading ☐ drawing / painting / crafts ☐ building (like Legos)
☐ playing video games alone ☐ playing video games with friends
☐ team sports (soccer, football) ☐ individual sports
☐ prefers to be outdoors ☐ prefers to be indoors
☐ Other_____

_____

When separating, what works for you and your child?

☐ needs some encouragement but otherwise separates well
☐ some crying, needs reassurance, sometimes distraction
☐ My child has never been separated from me or family
☐ Other_____

Mobility

How does your child move around?

☐ Walks
☐ Crawls
☐ Uses walker, crutches or cane(s)
☐ Uses Wheelchair ☐ Other: _____

Anything else we should know about your child's **mobility**?

Toileting

My child:

- ☐ Needs no help or reminders to go to the bathroom
- ☐ Wears a diaper
- ☐ Needs prompting to go to bathroom
  - How often: _____
  - What do you say to prompt: _____

How I know my child needs to use the bathroom: _____

Help my child needs when toileting

☐ None
☐ Clothing management
☐ Wiping / hygiene

Child's Name _____

Comfort/Security

We call parents when there is a serious medical issue. Are there any other reasons you would want us to call you?
(examples: Inconsolable or crying for a long period of time)

Emergency Contacts

1) Name:_____ Phone _____

2) Name:_____ Phone _____

For safety reasons, you or your designated caretaker may be required to provide a password upon picking your child up from Camp.

***Your family's password will be*:** _____

Child's Health History

Current height: _____ Weight: _____

Check if you child has any of the following conditions:

- ☐ Infections
- ☐ Diabetes
- ☐ Seizures/Convulsions (see below)
- ☐ Stomach or intestinal issues
- ☐ Urinary/Kidney difficulties
- ☐ Asthma, Bronchiolitis
- ☐ Allergies (other than to drugs)
- ☐ Respiratory/Breathing Problems
- ☐ High/Low Blood Pressure
- ☐ Sensitivities to: ☐ sun ☐ chlorine ☐ sunscreens

If you checked any of the above, please give details: _____

_____

Dietary

Does your child have any of these feeding or dietary concerns? (note: Camp Prov is nut-free and gluten free for our campers!)

- ☐ Gluten free
- ☐ feeding tube
- ☐ Nut allergy
- ☐ Other food allergy _____
- ☐ Casein free
- ☐ Diabetes
- ☐ Lactose intolerance
- ☐ Swallowing/choking

Child's Name _____

Medical Information

Does your child take medications? ☐ Yes ☐ No

If yes*, please list:

Name:	Dosage	Frequency

***Please Note*: Camp staff will *NOT* be able to administer medications except in life-threatening emergency. We are also unable to provide suctioning and/or providing tube feeding.**

List any medication allergies and their reactions

_____

_____

Any significant allergies that require EpiPen (or similar) left with RN while at camp

☐ Yes ☐ No

Seizure Information

If your child has seizures, please explain:

Frequency: _____ Length:_____

Date of most recent seizure: _____

Triggers: _____

What do the seizures look like (head bobbing, eyes roll back, blank stare, etc.)?:

_____

What should be our plan of care be if your child has a seizure while at Camp (Our typical response would be to call 911 immediately)

I will leave my child's emergency medications with RN all week

☐ Yes ☐ No

It is OK for my child to use the Sunscreen at Camp ☐ Yes ☐ No

Any other medical issues information you would like to report? (e.g. overheat easily, recent hospitalization, surgery, medical equipment etc.)

_____

Child's Name _____

_____

Please Note: *We cannot be responsible for any lost items at Camp. We highly recommend labeling all items brought to Camp with permanent pen.*

Checklist:

- **Please sign and return this application with:**
  - **copy of your child's immunization records (or declination of immunization)**
  - **Signed (attached) photo release (optional)**
  - **Provide payment per Payment Options (next page)**

Send all of the above to:
Providence Children's Center Camp Prov
900 Pacific Ave Suite 130, Everett WA 98201
-or-
FAXED to 425.258.7618

Due to the insecure nature of email, we would prefer you did not email forms to us.

Release/Permission

I verify that the above medical/health information on my child is complete and accurate. I also understand that all reasonable measures will be taken to safeguard the health and safety of all participants and I will be notified as soon as possible in the case of emergency affecting my child. In the event that I cannot be reached in an emergency, I hereby authorize you and a physician to render all services and treatment deemed necessary at my expense.

Parent / Guardian Signature: _____

Date:_____

Continued next page

Child's Name _____

Payment Options (please check)

☐ $130 for the full tuition

☐ $65 initial payment, with the remaining $65 due by 6/23/23

☐ My Child is DDA respite eligible, and am planning on using my child's hours for Camp Prov.

My Child's DDA number ☐☐☐☐☐☐☐☐☐WA

My Child's DDA Caseworkers Name_____

My Child's Caseworker's phone_____

My Child's Caseworker's email_____

DDA office location_____

☐ If you are interested in **financial aid** please check here and we will contact you. **No payment due at this time.**

☐ I would like information on sponsoring a child in need for Camp Prov

Payment enclosed ☐ Check
☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

Amount_____

Name on card _____

Number_____ EXP date_____

Zip Code associated with card_____

C.V.V. number_____

Signature authorizing credit / debit card

Providence Children's Center Camp Prov
900 Pacific Ave Suite 130, Everett WA 98201
Phone: 425.258.7311 ext 0 | FAX 425.258.7618 | Camp.Prov@providence.org

Child's Name _____

Child's Name _____

DO NOT WRITE OUTSIDE BORDER AREA

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS

1AUTH

1. I authorize Providence Health & Services to 1) interview, 2) photograph, and/or 3) videotape me and to use the interview(s), photograph(s), or videotape(s) in connection with marketing, public relations and other news media purposes which include but may not be limited to electronic or print media, brochures and other printed materials, displays, and/or radio and television. If the intended use is not included above, please indicate:

   Other Use: _____

   Name: (please print) _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Daytime Phone: _____

2. I understand that I have the right to request cessation of recording or filming, or interviewing.
3. I understand that the information used or disclosed pursuant to this authorization is not covered by federal privacy regulations, and that any health information disclosed may be re-disclosed and is no longer protected under federal law.
4. I understand that this authorization is for the uses listed above. The use of these materials for archival or historical purposes is part of PH&S operations and is not encompassed in this authorization.
5. I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
6. This authorization only applies to information created within 90 days from the date of this authorization. I understand that Providence Health & Services may use this information at any time up to five years from the date signed, or upon revocation, whichever occurs first. PH&S will honor my revocation to the extent this authorization has not been relied on for the creation and distribution of materials that include my information. To revoke this authorization, I must send a written statement, including my full name, address and phone number stating that I am revoking this authorization to:

   Marketing and Communications
   Providence Regional Medical Center Everett
   PO Box 1147, Everett WA 98206

7. I have read this authorization and I understand it, and affirm that I have reached the age of legal majority (18) according to the laws of Washington State. By:

   _____ Date: _____
   INDIVIDUAL/PERSONAL REPRESENTATIVE

   Personal Representative's Name (please print): _____

   Description of personal representative's authority: _____

   _____

For official Providence use only.

Name and title of PH&S employee arranging authorization: _____

Description of interview, photograph and/or videotape: _____

WHITE COPY: MEDICAL RECORD YELLOW COPY: MARKETING AND COMMUNICATION PINK COPY: PATIENT

PROVIDENCE Regional Medical Center Everett

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children
900 Pacific Ave. • Everett, WA 98206

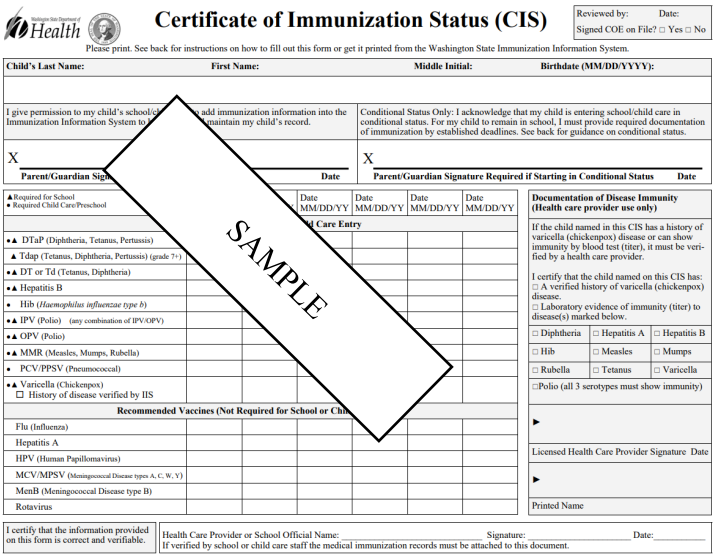
AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS (08/09)

#31591 (09/21/09) - D

Align Patient Sticker Here

Child's Name _____

We require proof of immunization or exemption. Below are samples of The Certificate of immunization like below or from your medical provider's office and the Exemption form. Certificate used must be signed by the provider.



Washington State Department of Health

Certificate of Immunization Status (CIS)

Reviewed by: Date:
Signed COE on File? □ Yes □ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System and maintain my child's record.

Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.

X _____ Parent/Guardian Signature Date

X _____ Parent/Guardian Signature Required if Starting in Conditional Status Date

▲Required for School
● Required Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Child Care Entry					
●▲ DTaP (Diphtheria, Tetanus, Pertussis)					
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)					
●▲ DT or Td (Tetanus, Diphtheria)					
●▲ Hepatitis B					
● Hib (*Haemophilus influenzae type b*)					
●▲ IPV (Polio) (any combination of IPV/OPV)					
●▲ OPV (Polio)					
●▲ MMR (Measles, Mumps, Rubella)					
● PCV/PPSV (Pneumococcal)					
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS					
Recommended Vaccines (Not Required for School or Child					
Flu (Influenza)					
Hepatitis A					
HPV (Human Papillomavirus)					
MCV/MPSV (Meningococcal Disease types A, C, W, Y)					
MenB (Meningococcal Disease type B)					
Rotavirus					

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

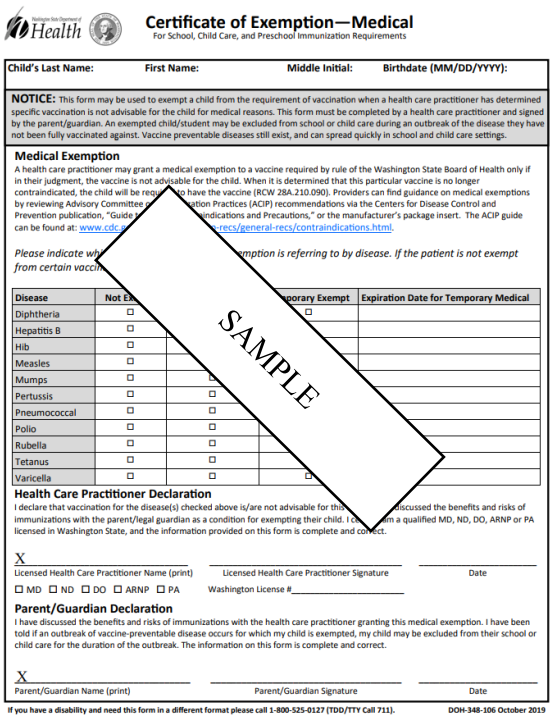
▶ _____
Licensed Health Care Provider Signature Date

▶ _____
Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date: _____
If verified by school or child care staff the medical immunization records must be attached to this document.

SAMPLE



Washington State Department of Health

Certificate of Exemption—Medical
For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings.

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in their judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 28A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Please indicate which vaccine the exemption is referring to by disease. If the patient is not exempt from certain vaccines, leave blank.

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
Diphtheria	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Hib	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal	☐	☐	☐	
Polio	☐	☐	☐	
Rubella	☐	☐	☐	
Tetanus	☐	☐	☐	
Varicella	☐	☐	☐	

Health Care Practitioner Declaration

I declare that vaccination for the disease(s) checked above is/are not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

X _____ _____ _____
Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

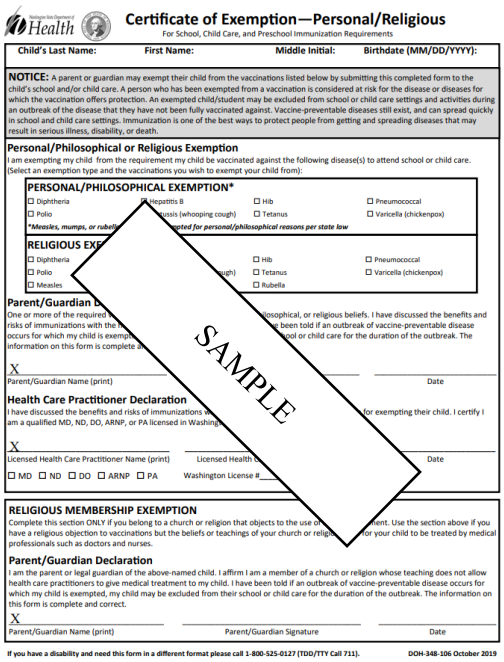
Parent/Guardian Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____
Parent/Guardian Name (print) Parent/Guardian Signature Date

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). DOH-348-106 October 2019

SAMPLE



Washington State Department of Health

Certificate of Exemption—Personal/Religious
For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: A parent or guardian may exempt their child from the vaccinations listed below by submitting this completed form to the child's school and/or child care. A person who has been exempted from a vaccination is considered at risk for the disease or diseases for which the vaccination offers protection. An exempted child/student may be excluded from school or child care settings and activities during an outbreak of the disease that they have not been fully vaccinated against. Vaccine-preventable diseases still exist, and can spread quickly in school and child care settings. Immunization is one of the best ways to protect people from getting and spreading diseases that may result in serious illness, disability, or death.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement my child be vaccinated against the following disease(s) to attend school or child care. (Select an exemption type and the vaccinations you wish to exempt your child from):

PERSONAL/PHILOSOPHICAL EXEMPTION*

☐ Diphtheria ☐ Hepatitis B ☐ Hib ☐ Pneumococcal
☐ Polio ☐ Pertussis (whooping cough) ☐ Tetanus ☐ Varicella (chickenpox)
**Measles, mumps, or rubella cannot be exempted for personal/philosophical reasons per state law*

RELIGIOUS EXEMPTION

☐ Diphtheria ☐ Hib ☐ Pneumococcal
☐ Polio ☐ Tetanus ☐ Varicella (chickenpox)
☐ Measles ☐ Rubella

Parent/Guardian Declaration

One or more of the required vaccinations conflicts with my personal, philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner granting this exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____
Parent/Guardian Name (print) Date

Health Care Practitioner Declaration

I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in Washington State, and the information provided on this form is complete and correct.

X _____ _____ _____
Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA Washington License #_____

RELIGIOUS MEMBERSHIP EXEMPTION

Complete this section ONLY if you belong to a church or religion that objects to the use of vaccinations in treatment. Use the section above if you have a religious objection to vaccinations but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses.

Parent/Guardian Declaration

I am the parent or legal guardian of the above-named child. I affirm I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment to my child. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X _____ _____ _____
Parent/Guardian Name (print) Parent/Guardian Signature Date

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). DOH-348-106 October 2019

SAMPLE