VIA WEST PAPERWORK PACKET

Thanks for choosing Via West. ☺ Please fill out the enclosed information packet. With the exception of the Medical Form, you will be able to complete the following forms on your own:

- **2018 Participant Application**
- **Medical Form**
- **Participant Health History**
- **Over the Counter Medication Form**
- **Medication Log**
- **Photo Release**
- **Field Trip Permission Slip**

Please have all paperwork completed and returned to MyHanh Duong as soon as possible, but no less than one month before the session. You have several return options as follows:

Mail: 2851 Park Avenue, Santa Clara, CA 95050

Email: mduong@viaservices.org

Fax: 408-243-0452

If you have any questions or concerns, please email MyHanh Duong or call 408-243-7861 extension 214. We are excited to have your participant at Via West and look forward to seeing you soon!

2018 Participant Application

Participant's Name: Last_____ First_____ Middle _____

Nickname: _____Age:_____ Date of Birth: ____/____/____ Gender:_____

Ethnicity: ☐White ☐Hispanic ☐Asian ☐African-American ☐Native American ☐Other _____

Participant's Home Address, Living at: STREET _____

CITY_____ STATE _____ ZIP_____

PHONE (_____)_____ COUNTY_____

Legal Guardian (primary emergency contact) _____

Guardian's Place of Employment: _____ _____

Relationship _____ Guardian's ADDRESS: STREET _____

CITY_____ STATE _____ ZIP_____

PHONE (Home) (_____)_____ PHONE (Work) (_____)_____

PHONE (Cell) (_____)_____ E-MAIL _____

Emergency Contact (other than guardian): Name _____

Relationship to Participant _____ Phone (_____)_____

Participants are assigned to sessions by VIA's administrative staff based on an assessment. We will make every effort to place a participant in the session(s) of your choice. Completed applications are processed as they are received on a first-come, first-served basis.

How many years has the participant attended our program? _____

Have they attended another program? _____

Please list program(s) and dates: _____

Is the participant a client of the Regional Center? _____ If so, which one? _____

Participant Care Information

Participant's Disability: _____
Please be specific to aid in staff assignment and program planning.

Is participant's cognitive age below the actual age? ☐Yes ☐No If so, what is approximate cognitive age?

Participant's staffing ratio requested:

☐3:1 ☐2:1 ☐1:1 ☐Don't know

*Final determination of participant's ratio will be assigned by VIA's administrative staff

Does participant use any of the following special equipment? Please check below.

Important: Participant should bring any of these he/she normally uses.

☐Wheelchair ☐Power Wheelchair ☐Leg Braces ☐Crutches ☐Prosthesis

☐Eyeglasses ☐Hearing Aid ☐Orthopedic Corrective Equipment (**Continued on next page**)

☐Catheter Equipment ☐Cochlear Implant ☐BiPAP or CPAP Machine ☐Nebulizer

☐GPS Locator ☐G-Tube Equipment ☐Vagal Nerve Stimulator & Magnet ☐Oxygen

☐Special Supports (head, back, brace, etc.) ☐Other _____

Please comment on any special care requirements or suggestions: _____

_____

Participant's Height/Weight: _____(Important for appropriate staff assignment)

Participant Walks: ☐Unaided ☐ With assistance ☐With braces/crutches/walker ☐Short Distances Only

Does participant wear helmet for protection against falls? ☐Yes ☐No

☐Uses a wheelchair: ☐All of the time ☐Some of the time ☐Needs chair for long distances

How far can the participant travel without chair? _____

Participant: ☐Wheels self – Independent ☐ Needs Partial Assistance ☐Needs Total Assistance

Transfers: ☐Independent ☐ Needs Partial Assistance ☐Needs Total Assistance

Please comment on preferred transferring technique: _____

_____

Does Participant use a lift to transfer? (Hoyer lift, etc.) ☐Yes ☐No If yes, please specify: _____

_____

***If lift is used at home and/or the participant is over 200 lbs and cannot assist with transfer, lift must be brought!**

Please check all the following that apply to the participant and provide **DETAILED INFORMATION**. Use another sheet of paper if necessary. **Answers to these questions will greatly aid counselors in providing care to your participant.**

Sleeping

participant: ☐Gets up during the night (please explain: goes to bathroom, sleepwalks, wanders, etc.)

_____

☐Needs to be turned during the night. Explain: _____

☐Has special night-time routine. Explain: _____

☐Displays specific night-time behaviors. Explain: _____

Comments: _____

Does participant need bed rails or other special night care? ☐Yes ☐No If yes, please specify: _____

_____

Eating and Drinking

Level of assistance: ☐Independent ☐Needs Partial Assistance ☐Needs Total Assistance

☐**U**ses adaptive equipment at meals (please explain: straw, eating utensils, bib, etc.): _____

_____

_____

☐Has specific diet/nutrition need or restrictions (please explain) _____

_____

☐Has Food allergy (please explain) _____

☐Has a G-Tube? ☐Yes ☐No If yes, does client also eat or drink by mouth? _____

Diabetic: ☐Yes ☐No If yes, ☐Type 1 Diabetes ☐Type 2 Diabetes

Washing/Bathing

participant: ☐Independent ☐Needs partial assistance ☐Needs total assistance ☐Uses shower chair/bench

☐Has special bathing needs. Explain: _____

Hygiene: ☐Independent ☐Needs partial assistance ☐Needs total assistance

If assistance is needed, explain: _____

Dressing

participant: ☐Independent ☐Needs partial assistance ☐Needs total assistance

If assistance is needed, explain: _____

Toilet

Participant: ☐Independent ☐Needs partial assistance ☐Needs total assistance

☐Has bladder control ☐Has bowel control

If assistance is required, How? ☐Getting to toilet ☐Getting on toilet ☐Wiping ☐Reminder

Has a special toileting procedure? Explain: _____

_____

☐Use a urinal ☐Tell you in advance? How much in advance? _____

☐Need to "sit" on the toilet How Long? _____ ☐Independent ☐Requires Assistance

☐Wet the Bed? How can this be prevented? _____

What are your participant's usual bathroom-stop times? _____

Catheter instructions: _____

☐ Have constipation problems? Explain: _____

Has girl's menstruation started? _____ Requires Assistance _____

Does your participant: ☐Wears briefs/diapers* If Yes, ☐All the time ☐At night only

***If "yes", be sure to send enough briefs/diapers for the entire session.**

Communication

Participant: ☐Speaks completely clearly ☐Speaks mostly clearly ☐Uses assisted communication device

☐Non-verbal ☐Uses sign language more than speech ☐Uses communication cards/icons

Please describe any communication devices/cards/etc.: _____

SPEAKS AND/OR UNDERSTANDS LANGUAGE OTHER THAN ENGLISH? ☐YES ☐NO WHAT LANGUAGE? _____

☐HAS SPECIAL SIGNALS FOR "YES" AND "NO"? EXPLAIN: _____

☐HAS SPECIAL SIGNALS FOR INDICATING BASIC NEEDS? PLEASE EXPLAIN EACH.

DRINK? _____ HUNGRY? _____

COLD? _____ HOT? _____

SICK? _____ THIRSTY? _____

ADDITIONAL COMMENTS: _____

☐WHAT DOES HIS/ HER BEHAVIOR LOOK LIKE IF ASKED TO REPEAT NON-UNDERSTOOD PHRASES? _____

_____

SOCIALIZATION/ BEHAVIORS

☐HAVE A FRIEND THAT IS ATTENDING? _____ IF THE PARTICIPANT HAS A FRIEND HE/SHE WOULD LIKE TO SHARE A LODGE WITH, PLEASE LIST FRIENDS NAME HERE: _____

(WE WILL TRY TO ACCOMMODATE YOUR REQUEST, BUT MAY NOT BE ABLE TO IN ALL CASES)

PARTICIPANT:

☐BEEN SEPARATED FROM THE FAMILY BEFORE? ☐YES ☐NO IF YES, HOW DID PARTICIPANT REACT? _____

_____

☐HAS ANY APPARENT EMOTIONAL PROBLEMS OR BOTHERSOME BEHAVIOR PATTERNS? EXPLAIN: _____

_____

HOW DO YOU REDIRECT BEHAVIORS? PLEASE DESCRIBE POSITIVE REINFORCEMENTS, ITEMS OR ACTIVITIES THAT ARE CALMING OR REWARDING _____

_____

☐HAS OCCASIONAL PERIODS WHEN TEMPER IS EXHIBITED? WHEN? _____

☐EXHIBITS DISRUPTIVE BEHAVIORS (BITING, KICKING, HAIR PULLING, THROWING OBJECTS, ETC.). PLEASE EXPLAIN: _____

_____

☐HAVE SELF-INJURIOUS BEHAVIORS? _____

☐HAVE DANGEROUS BEHAVIORS THAT COULD RESULT IN HARM TO SELF, OTHER PARTICIPANTS OR STAFF? _____

_____

☐ HAS THE PARTICIPANT HAD ANY ISSUES WITH INAPPROPRIATE SEXUAL BEHAVIORS, UP TO AND INCLUDING PREDATORY AND/OR VICTIM-LIKE BEHAVIORS: _____

PLEASE EXPLAIN THE BEST METHOD OF BEHAVIOR MANAGEMENT, IF NECESSARY: _____

_____

_____

☐Is on a **Behavior Management** plan? ☐Yes ☐No If yes, please attach a copy with this application.

☐Has any specific fears? Explain: _____

☐Has a tendency to wander from group? _____

If participant wanders, what is the best way to redirect towards group? _____

☐Dislikes group activities? _____

Other Information

Swimming

PLEASE NOTE: Lifeguards are on duty at each swim period and counselors provide in-water assistance.

Participant: ☐Swims ☐Needs full-time help in water ☐Needs life jacket sometimes

☐ Enjoys water ☐Does not like water ☐Requires life jacket

Comments: _____

Seizures

Have a history of seizures? ☐Yes ☐No Type: _____

Frequency _____ Duration _____

Appearance _____ Triggers/warning signs _____

Last seizure (if infrequent) _____ Post seizure/recovery _____

Instructions for handling seizures _____

List any special emergency care for seizures _____

Additional Comments _____

_____

Have a cardiac condition? ☐Yes ☐No If yes, list care and limitations: _____

_____

Have any severe respiratory problems? ☐Yes ☐No If yes, list care and limitations: _____

_____

Have allergies? ☐Yes ☐No If yes, LIST care and limitations: _____

_____

Activity restrictions: (e.g. swimming, campouts, cookouts, field trips, hikes, etc.) _____

_____

What are participant's interests and hobbies? _____

_____

_____

OTHER INFORMATION (CONTINUED)

DOES THE PARTICIPANT WANT TO COME TO PROGRAM? _____ PLEASE EXPLAIN: _____

_____

WHAT DO YOU WANT THE PARTICIPANT TO GAIN FROM HIS/HER STAY? _____

_____

INDICATE ANY OPERATIONS OR SERIOUS INJURIES RECENTLY INCURRED BY PARTICIPANT AND/OR RECENT CHANGES IN THE PARTICIPANT'S ENVIRONMENT/FAMILY:

_____

_____

WILL PARENTS POSSIBLY BE ON VACATION DURING SESSION? _____DOES PARTICIPANT KNOW? _____

IF YES, HOW CAN VIA COMMUNICATE WITH VACATIONING PARENT? (PLEASE GIVE COMPLETE INFORMATION ON WHERE THEY CAN BE CONTACTED: _____

_____

INSURANCE INFORMATION

NAME OF YOUR HEALTH INSURANCE COMPANY _____

CERTIFICATE NUMBER _____ MEDI-CAL NUMBER _____

A COPY OF INSURANCE CARD SHOULD ACCOMPANY APPLICATION.

ACCEPTANCE CONDITIONS

VIA SERVICES, INC. RESERVES THE RIGHT TO REFUSE TO PROVIDE SERVICES TO ANY INDIVIDUAL WHEN THE VIA WEST STAFF DETERMINES THAT THE INDIVIDUAL CANNOT BE PROVIDED ADEQUATE SUPORT BY VIA SERVICES, INC. THESE DECISIONS ARE MADE ON AN INDIVIDUAL BASIS, BY THE DIRECTOR OR THE VICE PRESIDENT OF PROGRAMS.

PARENTS, CARE PROVIDERS, AND THE REGIONAL CENTER (OR OTHER APPROPRIATE AGENCIES) WILL BE NOTIFIED IN THE EVENT OF ANY SERIOUS INJURY OR ILLNESS REQUIRING MORE THAN BASIC FIRST AID, OR IN THE CASE OF ANY SIGNIFICANT INCIDENT OR BEHAVIOR PROBLEM.

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN YOUR NAME BELOW

I AGREE TO THE ACCEPTANCE CONDITIONS ABOVE. SHOULD IT BECOME NECESSARY FOR MY PARTICIPANT TO LEAVE VIA WEST CAMPUS, OR ANY VIA SERVICES, INC. FUNCTION, FOR ANY REASON, I WILL MAKE PROVISIONS TO BRING THE PARTICIPANT HOME. I HEARBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND COMPLETE.

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL PERTINENT INFORMATION REGARDING THIS PARTICIPANT TO VIA SERVICES, INC. I AGREE TO NOTIFY VIA SERVICES, INC. OF ANY CHANGES THAT NEED TO BE MADE IN THIS APPLICATION BEFORE SESSION.

SIGNATURE _____

PRINT NAME _____

RELATIONSHIP TO PARTICIPANT _____ DATE _____

PARENTS/GUARDIAN CONSENT FORM

ASSUMPTION OF RISK: I, the undersigned parent or guardian of the below named participant, who desired to participate in activities at Via West Campus offered and organized by Via Services, Inc., hereby acknowledge that I am aware that there are significant risks associated with participation in program, including, without limitation, the risk of serious bodily injury or death. On behalf of myself, my spouse and participant, and our respective heirs, administrators, representatives and successors, I willingly assume such risk. By signing this document I am providing a clear, written expression of my agreement to assume all of the risks and dangers my participant may encounter at Via West Campus, and to never sue or make a claim against Via Services, Inc., or any of its employees or agents.

RELEASE AND WAIVER: In consideration of the permission granted by Via Services, Inc. for _____ _____ (participant) to participate in activities at Via West Campus the undersigned hereby agrees to release and discharge the organization, its officers, agents and employees from all claims, demands, actions or causes of action, which the participant, his or her personal representatives, heir and next to kin, may or might have against Via Services, Inc., its officers, agents and employees on account of injury to or death of the participant, or damage to the property of the participant arising out of the participant's participation in activities at Via West Campus. The undersigned further agrees to indemnify and hold harmless Via Services, Inc. for any loss, liability, damage or costs that may be incurred due to the acts of the participant during the participant's participation in activities at Via West Campus.

PERSONAL PROPERTY: The undersigned recognizes that Via Services, Inc. cannot accept responsibility for participant's personal property. To help eliminate losses, the undersigned has ensured that **all clothing is labeled with participant's name and a list of belongings has been included in luggage.**

MEDICAL RELEASE: In the event that an emergency should arise while _____ _____ (participant) is at Via West Campus, going or returning therefrom, requiring medical or surgical care or treatment, the undersigned authorizes Via West Campus staff and Via Services, Inc. to select and designate nurses, physicians, 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 Examiner's of the State of California, may be needed and proper. I authorize Via West Campus staff and Via Services, Inc. to render any aid and assistance to my participant, and to administer medication to my participant. I authorize the Via West Campus medical staff to dispense medications. I agree that medications for life threatening conditions (e.g., bee sting medications, inhaler), will be carried by a Via West Campus staff person and I authorize their use for my participant as needed. I agree to pay for any prescribed medication or treatment my participant may need. The undersigned releases and absolves Via Services, Inc. and nurses, physicians, and surgeons selected and designated by them, from any and all liability for their acts rendered in good faith. Parents/Guardians will be notified within 24 hours of any treatment sought.

Please sign below to acknowledge consent to conditions above:
BOTH PARENT'S SIGNATURES REQUIRED or (SINGLE PARENT/GUARDIAN WITH LEGAL CUSTODY):

_____ _____
Please specify your relationship: □ Mother □ Father □ Guardian DATE

_____ _____
Please specify your relationship: □ Mother □ Father □ Guardian DATE

IF PARTICIPANT IS RESPONSIBLE FOR HIS/HER OWN CARE AND/OR LEGAL AFFAIRS:

_____ _____
PARTICIPANT'S SIGNATURE DATE

Via West Campus
Via Services, Inc.
2851 Park Ave, Santa Clara, CA 95050
Phone (408) 243-7861
Fax (408) 243-0452

via services

Please note:
This form is good for two years from the date EXAMINED, not date form is signed.

MEDICAL FORM TO BE COMPLETED BY A LICENSED PHYSICIAN

Participant Name: _____ Birthdate: _____

HEALTH EXAMINATION BY LICENSED PHYSICIAN

I have examined the above individual. **Date examined:** _____ Form expires two years from **THIS** date.

In my opinion, the above individual's condition ☐ **does** ☐ **does not** **(check one)** allow participation in this program.

Participant's disability: _____ Participant's functional mental age: _____

Disability involves:

❑ Legs	❑ Head/Neck	❑ Breathing	❑ Learning
❑ Arms	❑ Vision	❑ Communication	❑ Social Adjustment
❑ Hands	❑ Hearing	❑ Speaking	❑ Behavior
❑ Trunk	❑ Coordination	❑ Understanding	❑ Other

HEALTH HISTORY

(Check, if applicable, giving approximate dates)

❑ Diabetes	❑ Heart Defect/Disease	❑ Bleeding/Clotting Disorders	❑ Asthma
❑ Frequent Ear Infections	❑ Hay Fever	❑ Chicken Pox	❑ Measles
❑ Hypertension	❑ German Measles (Rubella)	❑ Mumps	❑ Mononucleosis
❑ Down Syndrome			

ALLERGIES

Medicine (List) _____

Aspirin ☐ Y☐☐ N Penicillin ☐ Y☐☐ N Insects _____ Food _____ Other _____

SEIZURES: ☐ Y☐☐ N Type & frequency _____

_____ Date of Last seizure _____

MEDICATIONS (Please PRINT. Attach another sheet if necessary)

Medication	Dosage	Frequency

RECOMMENDATIONS / RESTRICTIONS AT VIA WEST CAMPUS:

Treatment plan to be continued at Via West Campus: _____

Activity restriction, if any _____

Medically prescribed meal plan or dietary restrictions: _____

IMMUNIZATION HISTORY:

Required immunizations must be determined locally. Please record the date (month and year) basic immunizations and most recent booster doses.

Polio	**Diptheria/Pertussis/ Tetanus**	**Measles/Mumps/ Rubella**	**Hepatitis**	**Pneumococcal**	**TB Test Given**
❑ 2-4 months	❑ 2-4 months	❑ 12-15 months	❑ Hep A	Date _____	Date _____
❑ 15 months	❑ 6 months	❑ 11-12 years	Date _____	Date _____	(most recent)
❑ 5 years	❑ 18 months	❑ Other	Date _____	Date _____	❑ Negative
❑ Other	❑ 5 years	Date _____	❑ Hep B		❑ Positive
Date _____	❑ 13-15 years		Date _____		
	❑ Adult		Date _____		
	Date _____		Date _____		

Licensed Physician's Signature: _____ Phone: _____

Address: _____

Street & Number City State Zip Code

Date of Form Completion: _____ By: _____

PARTICIPANT HEALTH HISTORY

Via West Campus
Via Services Inc.
2851 Park Ave. Santa Clara, CA 95050
Phone (408) 243-7861 fax (408) 243-0452

To be filled out by parent/guardian of minors OR by adult participants or their guardian/conservators once for summer sessions and once for weekend respite sessions.

Name: _____ ***Date of Birth:*** _____ ***Sex:*** _____ ***Age:*** _____
First Last Middle

Parent/Guardian (or Spouse): _____

Home Address: _____ Home Phone: (_____)_____
Street & Number City State Zip

Work Phone:(_____)_____ Cell Phone:(_____)_____ Pager: (_____)_____

Second Parent/Guardian or Caregiver: _____

Home Address: _____ Home Phone: (_____)_____
Street & Number City State Zip

Work Phone:(_____)_____ Cell Phone:(_____)_____ Pager: (_____)_____

Emergency Contact when Parent/Guardian cannot be reached (Mandatory): _____

Home Address: _____ Home Phone: (_____)_____
Street & Number City State Zip

Work Phone:(_____)_____ Cell Phone:(_____)_____ Pager: (_____)_____

HEALTH HISTORY:

(check and give approximate dates)

Allergies:

_____ Hay Fever
_____ Poison Ivy
_____ Insect Stings
_____ Penicillin
_____ Other Drugs (List)
_____
_____

Diseases:

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
_____ Asthma
_____ Mononucleosis

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Seizures

Disability, chronic or recurring illness_____

Has individual had operations or serious injuries? (If "yes" please give dates)_____

Has individual ever required psychiatric counseling/hospitalization? (If "yes" please give dates)_____

Date of Last Tetanus Shot: _____(month/year)

Dietary modifications/Food allergies_____

Any activities from which participant should be exempted or restricted for health reasons?_____

List of current prescription and over the counter medications: _____

Do you carry family medical/hospital insurance? _____ _____
Carrier Policy or Group Number

☐ All immunizations required for school or day program are up to date

IMPORTANT:THIS BOX MUST BE COMPLETED

This health history is correct so far as I know, and the individual listed above has permission to engage in all prescribed Via West activities except as noted. I hereby give permission to Via West: 1) To provide ongoing health care 2) To select medical personnel and to order X-Rays or routine tests or treatment for the individual listed above. Emergency Authorization: In the event that I cannot be reached in the event of an emergency, I hereby give permission to the physician selected by the Via West administration to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the individual named above. This form may be photocopied for use outside Via West.

Signature of Parent/Guardian or Adult Participant_____ Date _____

Witness_____ Date _____

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AN IMPORTANT MESSAGE REGARDING MEDICATION SAFETY AT VIA WEST CAMPUS

Dear Parent, Guardian or Conservator,

The nursing staff at Via West Campus is committed to providing a healthy and safe stay for our participants through a thoughtful and time-tested medication administration process. We appreciate your participation in this process to ensure that every participant receives the right drug at the right time.

When you arrive for check-in, you will meet with one of the members of our nursing staff to hand in all prescribed drugs, over the counter medications, vitamins, inhalers and injections that you would like for us to administer during your participant's stay.

The nurse will review each medication with you, complete a medication administration record (MAR) and then review the MAR with you to ensure that we have the right plan for your client. After this review, you will sign and date the MAR to indicate your agreement with the plan.

You are the expert when it comes to giving drugs to your participant, so please share with the nurse any tips or suggestions for successful medication administration. We are happy to comply with your recommendations for everyone's benefit.

To facilitate this meeting with the nurse, we ask that you follow these simple steps:

1. Bring every medication, including vitamins and over the counter products, such as ibuprofen, in its original container. Prescribed drugs will have a label from the pharmacy and products you purchase over the counter will have an FDA-approved set of ingredients and instructions.
2. It is a good idea to pack medications from home in a clear, self-sealing plastic bag to expedite the check-in process.
3. If you want us to follow the label on the prescription, all is well. **If you wish us to administer a different dose of the drug, we will need a note from the prescribing physician that approves this change.**
4. Please send extra pills or liquid medications for our nurses to use in case a medication is dropped, spit out or otherwise becomes unusable.
5. If your participant needs his/her medications in applesauce, we are happy to provide that for you. For all other special foods (e.g. pudding, crackers, yogurt), please send a supply that our nurses can use when administering the medications.
6. If your participant needs a special cup, straw or other equipment to take medications, don't forget to hand those over to the nurse at check-in.

During weekend sessions, our nursing staff will administer medications beginning with dinner at 6:30PM. If your participant requires medications before this time, please plan to give them before you leave Via West.

During summer sessions, our nursing staff will administer medications beginning with snack at 2:15 PM. If your participant requires medications before this time, please plan to give them before you leave Via West.

Many of our participants rely on prescription medications for disease management, behavior management or other health reasons. If your participant comes without crucial medications, we will ask you to either bring the medications before the first administration time or take the participant home with you.

~OVER~

via services

VIA WEST CAMPUS

Over-the-Counter Medications

May be given the following over the counter medication on a PRN basis if not contraindicated:

1. Acetaminophen or ibuprofen for elevated temperatures, headaches or minor aches and pains.
2. Acetaminophen, ibuprofen, *Midol*, or *Pamprin* for menstrual cramps.
3. Antihistamines for runny nose, sneezing, eye irritation, rash, or other signs and symptoms of allergies.
4. Decongestants for nasal congestion.
5. Oral rehydrating fluid for signs and symptoms of dehydration or overheating.
6. Antitussive/Expectorants for minor cough.
7. Oral stool softener or laxative, suppository, or enema for constipation.
8. Antidiarrheal oral medication for diarrhea.
9. Calamine lotion, hydrocortisone cream, or Technu for bug bites or skin rash
10. Triple antibiotic ointment for abrasions, minor lacerations, and other open skin areas.
11. Antifungal cream for athlete's feet or other fungal rashes
12. Antacids for stomach upset or indigestion
13. Burn ointment or gel for sunburn or other minor burns
14. Aspirin for chest pain suspected to be of cardiac origin
15. Epi-Pen or Epi-Pen Jr. IM for anaphylactic shock
16. Glucagon IM for low blood glucose in nonresponsive campers who have been diagnosed with diabetes
17. Glucose tablets or frosting for low blood glucose in campers who have been diagnosed with diabetes

PLEASE CHOOSE **ONE** OF THE FOLLOWING TWO OPTIONS LISTED BELOW:

YOUR CONSENT IS VALID UNTIL YOU WITHDRAW IT IN WRITING.

OPTION #1

_____ ☐**MAY** / ☐**MAY NOT** be given the above over-the-counter
(PRINT PARTICIPANT'S NAME) (Please check one) medications while at Via West Campus

_____
(PRINT PARENT/GUARDIAN NAME)

_____ _____
(PARENT/GUARDIAN SIGNATURE) (DATE)

OPTION #2

Please call me_____prior to administering the above mentioned over-the-counter medications to my child_____while at Via West Campus.
(PRINT PARENT/GUARDIAN'S NAME) (PRINT PARTICIPANT'S NAME)

_____ _____
(PARENT/GUARDIAN SIGNATURE) (DATE)

_____
(PHONE NUMBER)

PLEASE BE SURE TO SIGN THE FORM

MEDICATION LIST: VIA WEST CAMPUS

Participant Name: **Date:**

Medication Allergies (list specific allergies & reactions):

Food or Environmental Allergies (list specific allergies & reactions):

Dietary Restrictions:

Activity Restrictions:

Seizure Disorder (Please list the date of last seizure):

MEDICATION	STRENGTH	# of PILLS	TIMES	SPECIAL INSTRUCTIONS for ADMINISTERING MEDS (with juice/applesauce, crushed, etc.)

Parent/Guardian/Participant signature Date

Photo Release and Consent Agreement

I, the undersigned, hereby consent to the unrestricted use (including but not limited to promotional print materials and postings on Via Services' website, Facebook, Flickr, Twitter, Linked In, Google +, Youtube, Vimeo, and any other social media channels that may be adopted by Via Services in the future) by Via Services of my child's first name, image, or both, as may be recorded by video or photography, without compensation to my child or to me.

I further acknowledge that Via Services reserves the right to choose, position, caption, and edit the images as determined by Via Services in their sole discretion.

All negatives and positives, along with the prints and DVDs, shall constitute the property of Via Services, Inc., solely and completely.

Further, I specifically waive any and all claims of interest or title to such photographs, DVDs and/or the use of my child's first name, and specifically waive any claim of remuneration or compensation to me or my family.

I, the understated, being parent, guardian or conservator of the client whose name appears below, hereby consent to the foregoing conditions and warrant that I have the authority to give such consent.

I further understand that this consent is valid until I withdraw it in writing. Via Services ☐**MAY** / ☐**MAY NOT** ***use my child's photo as outlined above.***

****A photo is required for our files. Please provide a photo if you do not want Via Services to take the required photo of your child.****

Participant's Name: _____

Parent/Caregiver Signature: _____ Date: _____

Parent/Caregiver Print Name: _____

Relationship to Participant: _____

Phone: _____ Email: _____

Via Services Programs Field Trip Permission Slip and Liability Waiver

Your participant has the option of attending a field trip off campus during his/her Via West. We will be providing the transportation for this trip, and our vehicles are wheelchair accessible. We will be sending nurses, administering medications, and maintaining appropriate staffing ratios. There will be a member of the administrative staff who will communicate directly with parents if needed. If you do not wish for your participant to attend the field trip, there will be alternative programming available on campus.

Participant Name: _____ ☐**MAY** / ☐**MAY NOT** attend the field trips.

Parent/Guardian Name: _____

Phone Number: _____ Email: _____

WAIVER OF LIABILITY

I/we acknowledge that my/my child's voluntary participation on this field trip entails known, unknown, and unanticipated risks, hazards or dangers, which could result in or lead to physical or emotional injury, illness, death or disability. I/we understand that such risks cannot be eliminated without jeopardizing the essential qualities of the field trip. I/we understand and acknowledge that Via Rehabilitation Services (the "Organization") is not responsible for my/my child's safety or for eliminating these risks. I/WE EXPRESSLY AGREE AND PROMISE TO ACCEPT AND ASSUME ALL OF THE RISKS THAT EXIST IN THIS ACTIVITY, INCLUDING ALL RISKS OF PERSONAL INJURY OR DEATH OR DAMAGE TO MY/MY CHILD'S PROPERTY. My/my child's participation in this activity is completely and purely voluntary, and I/we elect to participate in spite of the risks.

I/we understand and agree that Via Rehabilitation Services is not responsible or liable, financially or otherwise, for any injuries, illnesses, accidents or other damages that occur to me/my child while I/my child attend(s) the field trip, including any such injuries that result from my/my child's participation in any programs and activities at the field trip location, or as may be caused by the Organization or its agents.

I/we understand that I am/we are responsible for the care of my/my child's property. Via Rehabilitation Services shall not be held responsible or liable for loss, damage, neglect, misplacement or theft of my/my child's property, regardless of how it occurred. I/we acknowledge that Via Rehabilitation Services is not responsible or liable for any items I/my child bring(s) to, use, or leave on the field trip.

I/WE AGREE THAT I/WE, AND ON BEHALF OF MY/MY CHILD'S SUCCESSORS, ASSIGNS, HEIRS, INSURERS, AGENTS, GUARDIANS AND LEGAL REPRESENTATIVES, HEREBY RELEASE VIA REHABILITATION SERVICES FROM, AND AGREE NOT TO SUE THE ORGANIZATION FOR, ANY RIGHTS, ACTIONS, CAUSES OF ACTION, LIABILITY, CLAIM, SUIT, OR EXPENSE IN ANY WAY ASSOCIATED WITH, ARISING FROM OR ARISING OUT OF, MY/MY CHILD'S PARTICIPATION ON A FIELD TRIP, OR MY/MY CHILD'S USE OF EQUIPMENT OR THE FACILITIES AT THE FIELD TRIP LOCATION, INCLUDING WITHOUT LIMITATION, THOSE ARISING OUT OF INJURY TO ME/MY CHILD OR MY/MY CHILD'S DEATH, OR LOSS OF USE OR DAMAGE TO MY/MY CHILD'S PROPERTY. Neither I nor anyone acting on my behalf will make a claim against Via Rehabilitation Services as a result of any loss, injury, damage or death suffered by me/my child. This release of liability includes any and all losses caused or alleged to be caused in whole or in part by the negligence of any Organization personnel to the fullest extent permitted by law.

I/WE HEREBY ACKNOWLEDGE THAT I/WE HAVE CAREFULLY READ THIS AGREEMENT, AND THAT I AM/WE ARE FAMILIAR WITH AND UNDERSTAND ITS CONTENTS. I AM/WE ARE AWARE THAT THIS IS A RELEASE OF ALL LIABILITY AND A PROMISE NOT TO SUE VIA REHABILITATION SERVICES. I HEREBY SIGN THIS AGREEMENT OF MY/OUR OWN FREE WILL. I FURTHER UNDERSTAND THAT MY CONSENT OR REFUSAL IS VALID UNTIL I WITHDRAW IT IN WRITING.

Parent/Guardian Signature: _____ Date: _____

Packing List

While we do have a laundry for **emergency purposes only**, you should **send enough clothing for the entire stay**. Please pack an extra shirt or pair of pants just in case. Please send a fabric laundry bag labeled with your participant's name so we can keep soiled clothing in one place.

Please fill out the checklist **prior** to your arrival at check-in. We hope this list will assist you in packing for our program, as well as reduce the number of lost items. **Please make sure that all clothing and personal effects are clearly labeled with the participant's full name.** This list will be used by Via West staff to help pack your participant's belongings on check out day. You should inspect your participant's bag before leaving Via West to ensure that all belongings are present and there are no items you don't recognize. Please remember that Via West is not responsible for lost or damaged personal property. Lost & Found items are held for a period of two weeks, after which we donate them to Goodwill. *** **Via recommends that clients bring only essential items.** ***

PANTS/JEANS/SWEAT PANTS

# of Item Packed	Type	Brand	Color	Staff Initials

SHORTS

# of Item Packed	Type	Brand	Color	Staff Initials

SHIRTS/SWEATSHIRTS

# of Item Packed	Type	Brand	Color	Staff Initials

UNDERWEAR

# of Item Packed	Type	Brand	Color	Staff Initials

~OVER~

SOCKS/SHOES

# of Item Packed	Type	Brand	Color	Staff Initials

SWIMSUIT

# of Item Packed	Type	Brand	Color	Staff Initials

JACKET

# of Item Packed	Type	Brand	Color	Staff Initials

ADAPTIVE EQUIPMENT

	Description/Color
☐ Manual Wheelchair	
☐ Electric Wheelchair	
☐ Charger	
☐ Walker	
☐ Cane/Crutches	
☐ Leg Braces	
☐ Back Brace	
☐ Glasses	
☐ Hearing Aids	
☐ Swimming Equipment	
☐ Other Adaptive Equipment	
☐ Other Adaptive Equipment	

BEDDING/TOWELS

(Please remember that Via West will provide all bedding)

	#	Brand & Color
☐ Bath Towel		
☐ Beach Towel		
☐ Washcloth		
☐ Sleeping Bag		
☐ Pillow		
☐ Pillowcase		
☐ Laundry Bag		
☐ Other		

OTHER MISC. ITEMS

☐ Books	
☐ Toys	
☐ Other	
☐ Other	
☐ Other	

PERSONAL HYGIENE ITEMS

	#	Brand & Color
☐ Razor		
☐ Shaving Cream		
☐ Hairbrush		
☐ Shampoo		
☐ Conditioner		
☐ Soap		
☐ Deodorant		
☐ Toothbrush		
☐ Toothpaste		
☐ Sunscreen		
☐ Insect Repellant		
☐ Day Diapers		
☐ Night Diapers		
☐ Sanitary Napkins		
☐ Other		
☐ Other		
☐ Other		

Please note: If your participant wears diapers, please make sure to send a generous supply of diapers, wipes, liners, etc. Due to the difference in diet and environment, more of these supplies may be needed.