VIA WEST PAPERWORK PACKET

Dear Families,

Thanks for choose Via West! We are very excited to have you join us!

Please read the following instructions carefully to make sure that you provide us with the information that we require in a timely manner. Please review and 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:

- **2019 Participant Application**
- **Medical Form**
- **Participant Health History**
- **Over the Counter Medication Form**
- **Medication Log**
- **Photo Release**
- **Field Trip Permission Slip**
- **Photo of the participant**

MAIL: 2851 Park Ave, Santa Clara, CA 95050
EMAIL: mduong@viaservices.org
FAX: (408) 243-0452

Please have all paperwork completed and returned as soon as possible. Deadline is **31 days** prior to session. All forms should be scanned and emailed to our admissions office manager MyHanh Duong at mduong@viaservices.org or faxed to **(408) 243-0452**. You can also mail to **2851 Park Ave, Santa Clara, CA 95050**. If you have any questions or concerns, please email MyHanh Duong or call **408-243-7861 ext. 214**. We are excited to have your participant at Via West and look forward to seeing you soon!

via services

2019 PARTICIPANT APPLICATION

PARTICIPANT'S NAME: LAST _____ FIRST _____ MIDDLE _____

NICKNAME: _____ AGE: _____ DATE OF BIRTH: _____/_____/_____ GENDER: _____

ETHNICITY: ☐ WHITE ☐ HISPANIC ☐ASIAN ☐ AFRICAN-AMERICAN ☐ NATIVE AMERICAN ☐ OTHER

LEGAL GUARDIAN (PRIMARY EMERGENCY CONTACT) _____

RELATIONSHIP: _____ GUARDIAN'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____

GUARDIANS PLACE OF EMPLOYMENT: _____

HOME PHONE (___) _____ - _____ WORK PHONE (___) _____ - _____

CELL PHONE (___) _____ - _____ EMAIL _____

EMERGENCY CONTACT (OTHER THAN GUARDIAN) _____

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 THE VIA WEST PROGRAM? _____

HAVE THEY ATTENDED ANOTHER CAMP PROGRAM? _____

PLEASE IST THE PROGRAM(S) AND DATES _____

IS THE PARTICIPANT A CLIENT OF THE REGIONAL CENTER? _____ IF SO, WHICH ONE? _____

NAME OF SERVICE COORDINATOR _____ UCI # _____

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.

PARTICIPANT CARE INFORMATION

PARTICIPANT DIAGONSIS: _____

PLEASE BE SPECIFIC TO AID IN STAFF ASSIGNMENT AND PROGRAM PLANNING

IS THE PARTICIPANT COGNITIVE AGE BELOW THE ACTUAL AGE? ☐ YES ☐ NO

WHAT IS THE PARTICIPANT'S 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 ADMINISTRATIVE STAFF

DOES PARTICIPANT USE ANY SPECIAL EQUIPMENT? IF SO, PLEASE STATE BELOW:

IMPORTANT: PARTICIPANT SHOULD BRING ANY OF THESE ITEMS THAT HE/SHE NORMALLY USES*

☐ Wheelchair ☐ Power Wheelchair ☐ Leg Braces ☐ Crutches ☐ Prosthesis
☐ Eye Glasses ☐ Hearing Aid ☐ Orthopedic Corrective Equipment
☐ Catheter Equipment ☐ Cochlear Implant ☐ BiPAP or CPAP ☐ Nebulizer ☐ GPS Locator
☐ G-Tube ☐ Vagal Nerve Stimulator/Magnet ☐ Oxygen ☐ Special Supports – head, back, brace

PLEASE COMMENT ON ANY SPECIAL CARE REQUIREMENTS OR SUGGESTIONS: _____

_____

PARTICIPANT'S HEIGHT: _____ PARTICIPANT'S WEIGHT: _____

PARTICIPANT WALKS: ☐ UNAIDED ☐ WITH ASSISTANCE ☐ WITH BRACES/CRUTCHES/WALKER ☐ SHORT DISTS ONLY

DOES PARTICIPANT WEAR HELMET FOR PROTECT AGAINST FALLS? ☐ YES ☐ NO

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. ANSWER TO THESE QUESTIONS WILL GREATLY AID COUNSELORS IN PROVIDING CARE TO YOUR PARTICIPANT.

SLEEPING

☐ GETS UP DURING THE NIGHT (PLEASE EXPLAIN: EX. GOES TO THE BATHROOM, SLEEP WALKS, WANDERS, ETC.)

_____

☐ NEEDS TO BE TURNED AT NIGHT _____

☐ HAS A SPECIAL NIGHT-TIME ROUTINE _____

COMMENTS: _____

_____

☐ DISPLAYS SPECIFIC NIGHT-TIME BEHAVIORS. EXPLAIN: _____

COMMENTS: _____

_____

DOES THE 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

☐ USES ADAPTIVE EQUIPMENT AT MEALS (PLEASE EXPLAIN: STRAW, EATING UTENSILS, BIB, ETC.) _____

_____

☐ HAS A SPECIFIC DIET/NUTRITION NEED OR RESTRICTIONS (PLEASE EXPLAIN) _____

_____

☐ HAS FOOD ALLERGY (PLEASE EXPLAIN) _____

☐ HAS G-TUBE? ☐ YES ☐ NO IF YES, DOES CLIENT ALSO EAT/DRINK BY MOUTH? _____

DIABETIC: ☐ YES ☐ NO IF YES, ☐ TYPE 1 DIABETES ☐ TYPE 2 DIABETES

WASHING/BATHING

LEVEL OF ASSISTANCE: ☐ INDEPENDENT ☐ NEEDS PARTIAL ASSISTANCE ☐ NEEDS TOTAL ASSISTANCE

☐ 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 VERBAL REMINDERS/PROMPTING

IF ASSISTANCE IS NEEDED, EXPLAIN: _____

TOILETING

LEVEL OF ASSISTANCE: ☐ INDEPENDENT ☐ NEEDS PARTIAL ASSISTANCE ☐ NEEDS TOTAL ASSISTANCE

☐ HAS BLADDER CONTROL ☐ HAS BOWEL CONTROL ☐ NEEDS ASSISTANCE GETTING TO TOILET

☐ NEEDS ASSISTANCE ONTO THE TOILET ☐ WIPING ☐ PROMPTING/REMINDERS

HAS SPECIAL TOILETING PROCEDURE _____

_____

WHAT ARE YOUR PARTICIPANT'S USUAL BATHROOM-STOP TIMES? _____

CATHETER INSTRUCTIONS _____

_____

☐ USES A URINAL ☐ WILL TELL YOU IN ADVANCE? HOW MUCH IN ADVANCE? _____

☐ NEED TO SIT ON THE TOILET FOR HOW LONG? _____ ☐ INDEPENDENT ☐ REQUIRES ASST.

☐ WET THE BED? HOW CAN THIS BE PREVENTED? _____

HAS GIRL'S MENSTRUATION STARTED? ☐ YES ☐ NO REQUIRES ASSISTANCE? _____

☐ HAS CONSTIPATION PROBLEMS? EXPLAIN: _____

DOES YOUR PARTICIPANT ☐ WEAR BRIEFS/DIAPERS* IF YES, ☐ALL THE TIME ☐ AT NIGHT ONLY

***IF "YES", BE NSURE TO SEND ENOUGH BRIEFS/DIAPERS FOR THE ENTIRE SESSION.**

COMMUNICATION

PARTICIPANT: ☐ SPEAKS COMPLETELY CLEARLY ☐SPEAKS MOSTLY CLEARLY ☐ USED ASSISTED COMMUNICATION DEVICE

☐ NON-VERBAL ☐ USES ISGN 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 SIGNAL SIGNALS FOR INDICATING BASIC NEEDS? PLEASE EXPLAIN ECT.

DRINK? _____ HUNGRY _____

COLD? _____ HOT? _____

SICK? _____ THIRSTY? _____

ADDITIONAL COMMENTS _____

_____

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

_____

SOCIALIATION/BEHAVIORS

PARTICIPANT:

☐HAVE A FRIEND THAT IS ATTENDING?

IF THE PARTICIPANT HAS A FRIEND HE/SHE WOULD LIKE TO SHARE A LODGE WITH, PLEASE LIST THE FRIENDS NAME HERE: _____

_____

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

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

_____

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

_____

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

_____

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

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

_____

_____

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

_____

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

_____

☐ HAS ANY SPECIFIC FEARS? EXPLAIN: _____

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 THE GROUP? _____

☐DISLIKES GROUP ACTIVITIES? _____

SWIMMING

PLEASE NOTE: LIFEGUARDS ARE ON DUTY AT EACH SIWM PERIOD AND COUNSELORS PROVIDE IN-WATER ASSISTANCE.

PARTICIPANT: ☐ SWIM ☐ 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 _____

LAST SEIZURE (IF IN FREQUENT) _____ 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 ANY ALLERGIES? ☐ YES ☐ NO

IF YES, LIST CARE AND LIMITATIONS: _____

_____

ACTIVITY RESTRICTIONS (E.G., SWIMMING, CAMPOUTS, COOKOUTS, FIELD TRIPS, HIKES, ETC.): _____

_____

OTHER INFORMATION

WHAT ARE PARTICIPANT'S INTERESTS AND HOBBIES? _____

_____

DOES THE PARTICIPANT WANT TO COME TO THE PROGRAM? ☐ YES ☐ NO

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 THJE

PARTICIPANT'S ENVIRONMENT/FAMILY: _____

_____

WILL PARENTS POSSIBLY BE ON VACATION DURING SESSION? ☐ YES ☐ NO

DOES PARTICIPANT KNOW? ☐ YES ☐ NO

IF YES, HOW CAN CAMP ALTITUTE STAFF 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 _____ 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 Examiners 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 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 and (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 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 PHYSICAN

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:
(Check, if applicable, giving approximate dates)

☐	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	☐	Asthma
☐	Frequent Ear Infections	☐	Hay Fever		Disorder	☐	Measles
		☐	Chicken Pox	☐	Mumps	☐	Mononucleosis
☐	Hypertension	☐	German Measles (Rubella)			☐	Other

ALLERGIES

Medication (List) _____
Aspirin ☐ YES ☐ NO Penicillin ☐ YES ☐ NO Insects _____ Foods _____Other _____

Seizures ☐ YES ☐ NO Type and frequency _____ Date _____

MEDICATION **(Please PRINT. Attach another sheet if necessary)**

Medication Dosage Frequency

_____
_____
_____

RECOMMENDATION 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 ☐15months ☐ 5 years ☐ Other Date _____	☐ 2-4 months ☐ 6 months ☐ 18 months ☐ 5 years Date _____	☐ 12-15 months ☐ 11-12 years ☐ Other Date _____	☐Hep A Date _____ Date _____ ☐Hep B Date _____ Date _____	Date _____ Date _____ Date _____	☐ TB Test Given Date _____ ☐Negative ☐ Positive

Licensed Physician Signature: _____ Phone: _____
Address: _____ City _____ State _____ Zip Code _____
Date of Form Completion: _____ By: _____

via services

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:** _____

Parent/Guardian (or Spouse) Information

Home Address: _____ Home Phone (___) _____

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

Second Parent Guardian/Caregiver Information

Home Address: _____ Home Phone (___) _____

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

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

Home Address: _____ Home Phone (___) _____

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

HEALTH HISTORY:
(Check and give approximate dates)

Allergies	Diseases	
☐ Hay Fever	☐ Chicken Pox	☐ Mononucleosis
☐ Poison Ivy	☐ Measles	☐ Frequent Ear Infections
☐ Insect Stings	☐ German Measles	☐ Heart Defect/Disease Diabetes
☐ Penicillin	☐ Mumps	☐ Bleeding/Clotting Disorders
☐ Other Drugs	☐ Asthma	☐ Hypertension ☐ Seizures
Date _____	Date _____	Date _____
Date _____	Date _____	Date _____

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) _____

Diet 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:

Name of family medical/hospital insurance? _____ Policy/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 _____

AN IMPORTANT MESSAGE REGARDING MEDCATION 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 are 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.

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

OPTION #1

_____ ☐ MAY ☐ MAY NOT be given the above over the counter medication
Print Participant's Name Please Check One

_____
Print Parent/Guardian Name

_____
Parent/Guardian Signature Date: _____

OPTION #2

Please call me _____ prior to administering the above mentioned over the
Print Parent/Guardian Name
counter medication to my child _____ while at Via West Campus.
Print Participant's Name

_____
Parent/Guardian Signature Date: _____

_____
Phone Number

MEDICATION LIST: VIA WEST CAMPUS

Participant's Name _____

Medication Allergies (list specific allergies and reactions): _____

_____

_____

Food or Environmental Allergies (list specific allergies and reactions): _____

_____

_____

Dietary Restrictions: _____

_____

_____

Activity Restrictions: _____

_____

_____

Seizure Disorder ☐Yes ☐ No If yes, please list the date of last occurrence: _____

MEDICATION	STRENGTH	# OF PILLS	FREQUENCY	SPECIAL INSTRUCTIONS FOR ADMINISTERING MEDICATION (w/ apple sauce, crushed etc.)

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 REPRESENTATIV ES, HEREBY RELEASE VIA REHABILITATION SERVICES FROM, AND AGRE E 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 Services 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(s) Packed	Type	Brand	Color	Staff Initials

SHORTS

# of Item(s) Packed	Type	Brand	Color	Staff Initials

SHIRTS/SWEATSHIRTS

# of Item(s) Packed	Type	Brand	Color	Staff Initials

UNDERWEAR

# of Item(s) Packed	Type	Brand	Color	Staff Initials

SOCKS/SHOES

# of Item(s) Packed	Type	Brand	Color	Staff Initials

SWIM SUIT

# of Item(s) Packed	Type	Brand	Color	Staff Initials

JACKET

# of Item(s) Packed	Type	Brand	Color	Staff Initials

ADAPTIVE EQUIPMENT

# of Item(s) Packed	Type	Brand	Color	Staff Initials

☐ Manual/Electric Wheel Chair
☐ Charger
☐ Walker
☐ Cane/Crutches
☐ Leg Braces
☐ Back Brace
☐ Glasses
☐ Hearing Aids
☐ Swimming Equipment
☐ Other Adaptive Equipment _____

Bedding/Towels

(*Please remember that Via will provide bedding*)

☐ Bath Towel
☐ Beach Towel
☐ Wash Cloth
☐ Sleeping Bag
☐ Pillow
☐ Pillowcase
☐ Laundry Bag
☐ Other

Other Misc. Items

☐ Books
☐ Toys
☐ Other _____
☐ Other _____
☐ Other _____

Personal Hygiene Items

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

Please note: I f 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.