



## Via West Participant Paperwork Packet

Thank you for choosing Via West! Please complete the enclosed information packet. Please note that the Medical Form will need to be submitted to your participant's primary health care provider for completion.

- 2017 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 as soon as possible, but no less than one month before the session. You have several return options as follows:

Mail: 2851 Park Ave, Santa Clara, CA 95050

Fax: 408-243-0452

If you have any questions, please contact the Via West Admissions Manager at 408-243-7861, ext. 214. We are excited to have your participant at Via West and look forward to seeing you soon!



# Via West 2017 Participant Application

Participant Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Nickname \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_

Ethnicity White Hispanic Asian African-American Native American Other

Participant Home Address, Living At Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Legal Guardian (Primary Emergency Contact) \_\_\_\_\_ Relationship \_\_\_\_\_

Place of Employment \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact (Other than Guardian) \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

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 Diagnosis \_\_\_\_\_

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 the approximate cognitive age?

Requested staffing ratio for participant 3:1 2:1 1:1 Don't Know (Please note that 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 normally used)

Wheelchair Power Wheelchair Leg Braces Crutches Prosthesis Eyeglasses Hearing Aid

Orthopedic Corrective Equipment 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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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 Wheelchair  Always  Sometimes  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 200lbs and cannot assist with transfer, lift must be brought to campus.

For the following sections, please check all of 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

Uses adaptive equipment at meals (Please explain. Straw, eating utensils, bib, etc.) \_\_\_\_\_

Has specific diet/nutrition need or restrictions (Please explain.) \_\_\_\_\_



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Has food allergy (Please explain.) \_\_\_\_\_

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

Level of assistance  Independent  Needs Partial Assistance  Needs Total Assistance  Uses Shower Chair/Bench

Has special bathing needs (Please explain.) \_\_\_\_\_

Hygiene level of assistance  Independent  Needs Partial Assistance  Needs Total Assistance

If assistance is needed, please explain \_\_\_\_\_

### Dressing

Level of assistance  Independent  Needs Partial Assistance  Needs Total Assistance

If assistance is needed, please explain \_\_\_\_\_

### Toilet

Level of assistance  Independent  Needs Partial Assistance  Needs Total Assistance  Has Bladder Control

Has Bowel Control

If assistance is requires, how?  Getting to Toilet  Getting on Toilet  Wiping  Reminder

Has a special toileting procedure (Please explain.) \_\_\_\_\_

Uses a urinal  Tells you in advance of needing to go How much in advance? \_\_\_\_\_

Needs to sit on toilet? How long? \_\_\_\_\_  Independent  Requires Assistance

Wets the bed? How can this be prevented? \_\_\_\_\_

Participant's usual bathroom stop times? \_\_\_\_\_

Catheter instructions \_\_\_\_\_

Has constipation problems (Please explain.) \_\_\_\_\_

Female menstruation has started  Requires Assistance (Please explain.) \_\_\_\_\_

Wears diapers/briefs\* If yes,  All the Time  At Night Only

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

### Communication

Speaks Completely Clearly  Speaks Mostly Clearly  Uses Assisted Communication Device  Non-Verbal

Uses Sign Language More Than Speech  Uses Communication Cards/Icons

Describe communication devices/cards/etc. \_\_\_\_\_



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Speaks and/or understands language other than English (Which language?) \_\_\_\_\_

Has special signals for "yes" and "no" (Please explain.) \_\_\_\_\_

Has special signals for indicating basic needs (Please explain each.) Drink \_\_\_\_\_ Hungry \_\_\_\_\_

Cold \_\_\_\_\_ Hot \_\_\_\_\_ Sick \_\_\_\_\_ Thirsty \_\_\_\_\_

Additional Comments \_\_\_\_\_

What does behavior look like if asked to repeat non-understood phrases? \_\_\_\_\_

\_\_\_\_\_

### Socialization/Behaviors

Has friend attending same session If participant would like to share a lodge with friend, please list names here \_\_\_\_\_

\_\_\_\_\_

(We will try to accommodate your request for shared lodging, but we may not be able to in all cases.)

Has been separated from family before How did participant react? \_\_\_\_\_

\_\_\_\_\_

Has any apparent emotional problems or bothersome behavior patterns (Please explain.) \_\_\_\_\_

\_\_\_\_\_

How do you redirect behaviors? Please describe positive reinforcements, items, or activities that are calming or rewarding.

\_\_\_\_\_

\_\_\_\_\_

Has occasional period when temper is exhibited (Please explain.) \_\_\_\_\_

Exhibits disruptive behaviors like biting, kicking, hair pulling, throwing objects, etc. (Please explain.) \_\_\_\_\_

\_\_\_\_\_

Has self-injurious behaviors (Please explain.) \_\_\_\_\_

Has dangerous behaviors that could result in harm to self, other participants, or staff (Please explain.) \_\_\_\_\_

\_\_\_\_\_

Has had issues with inappropriate sexual behaviors up to and including predatory and/or victim-like behaviors (Please explain.) \_\_\_\_\_

\_\_\_\_\_

Please explain the best method of behavior management if necessary \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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- Has behavior management plan (Please attach a copy with this application.)
- Has specific fears (Please explain.) \_\_\_\_\_
- Has tendency to wander from group What is the best way to redirect towards group? \_\_\_\_\_
- Dislikes group activities (Please explain.) \_\_\_\_\_

### Swimming

Please note that lifeguards are on duty at each swim period and counselors provide in-water assistance.

- Level of assistance  Swims Independently  Needs Full-Time Help in Water  Needs Life Jacket Sometimes
- Enjoys Water  Does Not Like Water  Requires Life Jacket Full-Time Additional Comments \_\_\_\_\_

### Seizures

- Has history of seizures Type of seizures \_\_\_\_\_
- Frequency \_\_\_\_\_ Duration \_\_\_\_\_
- Appearance \_\_\_\_\_ Triggers/Warning Signs \_\_\_\_\_
- Last Seizure (if infrequent) \_\_\_\_\_ Post Seizure Recovery \_\_\_\_\_
- Instructions for Handling Seizures \_\_\_\_\_
- Additional Comments \_\_\_\_\_

### Additional Information

- Has cardiac condition (Please list care and limitations.) \_\_\_\_\_
- Has severe respiratory problems (Please list care and limitations.) \_\_\_\_\_
- Has allergies (Please list care and limitations.) \_\_\_\_\_
- Activity restrictions (swimming, campout, cookout, field trips, hikes, etc.) \_\_\_\_\_
- What are your participant's interests and hobbies? \_\_\_\_\_
- Does participant want to come to camp (Please explain.) \_\_\_\_\_



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What do you want your 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 parent/caregiver be on vacation during session and does your participant know this? \_\_\_\_\_

If parent/caregiver will be on vacation, how can Via communicate? Please give complete information on where we can contact you. \_\_\_\_\_

### Insurance Information

Name of insurance company \_\_\_\_\_ Certificate Number \_\_\_\_\_

Medi-Cal Number \_\_\_\_\_ 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 support 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 hereby 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 the session.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Participant \_\_\_\_\_ Date \_\_\_\_\_



# Via West 2017 Participant Application

## Parent/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 the 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 or 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 (ex. 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





# Medical Form To Be Completed By A Licensed Physician

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

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 diagnosis \_\_\_\_\_ Participant's functional mental age \_\_\_\_\_

Disability involves:

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

### HEALTH HISTORY

(Check, if applicable, giving approximate dates)

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

### 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 dates.

Polio	Diphtheria/Pertussis/Tetanus	Measles/Mumps/Rubella	Hepatitis	Pneumococcal	TB Test Given
<input type="checkbox"/> 2-4 mo.	<input type="checkbox"/> 2-4 mo.	<input type="checkbox"/> 12-15 mo.	<input type="checkbox"/> Hep A	Date _____	Date _____
<input type="checkbox"/> 15 mo.	<input type="checkbox"/> 6 mo.	<input type="checkbox"/> 11-12 yr.	Date _____	Date _____	(most recent)
<input type="checkbox"/> 5 yr.	<input type="checkbox"/> 18 mo.	<input type="checkbox"/> Other	<input type="checkbox"/> Hep B	Date _____	<input type="checkbox"/> Negative
<input type="checkbox"/> Other	<input type="checkbox"/> 5 yr.	Date _____	Date _____		<input type="checkbox"/> Positive
Date _____	<input type="checkbox"/> 13-15 yr.		Date _____		
	<input type="checkbox"/> Adult		Date _____		
	Date _____				

Licensed Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (Street & Number, City, State, Zip) \_\_\_\_\_

Date of Form Completion: \_\_\_\_\_ By: \_\_\_\_\_



# Participant Health History

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.

### CONTACT INFORMATION

Participant Name (First Last Middle) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Parent/Guardian (or Spouse) Name \_\_\_\_\_ Home Address (Street & Number, City, State, Zip) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Second Parent/Guardian (or Spouse) Name \_\_\_\_\_ Home Address (Street & Number, City, State, Zip) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact when Parent/Guardian cannot be reached. **MANDATORY.** Name \_\_\_\_\_

Home Address (Street & Number, City, State, Zip) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

### 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 \_\_\_\_\_

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 of Via West Campus.

Signature of Parent/Guardian or Adult Participant \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



## Over the Counter Medication Form

### 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 participant. 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 (ex. 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, do not forget to hand those over to the nurse at check-in.

During fall, winter, and spring 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 2:15pm. 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 the Counter Medication Form

### Over the Counter Medications

Participant 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 foot 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 participants who have been diagnosed with diabetes
17. Glucose tablets or frosting for low blood glucose in participants who have been diagnosed with diabetes

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

#### Option #1

\_\_\_\_\_ MAY MAY NOT be given above or over the counter medications while at Via West Campus  
PRINT PARTICIPANT'S NAME PLEASE CHECK ONE

\_\_\_\_\_  
PRINT PARENT/GUARDIAN'S NAME

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

#### Option #2

Please call me \_\_\_\_\_ prior to administering the above mentioned over the counter medications  
PRINT PARENT/GUARDIAN'S NAME  
to my child \_\_\_\_\_ while at Via West Campus.  
PRINT PARTICIPANT'S NAME

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHONE NUMBER

**YOUR CONSENT IS VALID UNTIL YOU WITHDRAW IT IN WRITING**

## Medication List

Participant Name \_\_\_\_\_

Date \_\_\_\_\_

Medication Allergies (List specific allergies and reactions)

Food or Environmental Allergies (List specific allergies and reactions)

Dietary Restrictions Activity Restrictions

Activity Restrictions

Seizure Disorder (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 the Via Services website, Facebook, Flickr, Twitter, LinkedIn, Google +, YouTube, Vimeo, and any other social media channels that may be adopted by Via Services, Inc. in the future) by Via Services, Inc. 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, Inc. reserves the right to choose, position, caption, and edit the images as determined by Via Services, Inc. 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 or refusal 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 client files. If you do not wish for the Via Services, Inc. photographer to take this photo, you must provide your own photo to be included with your participant's application.**

Participant Name \_\_\_\_\_

Parent/Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Caregiver Print Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_



## Field Trip Permission Slip and Liability Waiver

Your participant has the option of attending a field trip off campus during his/her stay at Via West Campus. 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.

**I understand that this consent or refusal is valid until I withdraw it in writing.**

Participant Name \_\_\_\_\_ MAY MAY NOT attend the field trips.

Parent/Caregiver Print Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Phone \_\_\_\_\_ 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 Services, Inc. (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 Services, Inc. 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 Services, Inc. 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 Services, Inc. is not responsible or liable for any items I/my child bring(s) to, uses, or leaves on the field trip.

I/WE AGREE THAT I/WE, AND ON BEHALF OF MY/MY CHILD'S SUCCESSORS, ASSIGNS, HERS, INSURERS, AGENTS, GUARDIANS, AND LEGAL REPRESENTATIVES, HEREBY RELEASE VIA SERVICES, INC. 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 CHILD'S PROPERTY. Neither I nor anyone acting on my behalf will make a claim against Via Services, Inc. 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 LIABILITY AND A PROMISE NOT TO SUE VIA SERVICES, INC. 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

### 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

### BEDDING/TOWELS

(Please remember that Via West will provide all bedding)

	#	Brand & Color
<input type="checkbox"/> Bath Towel	_____	_____
<input type="checkbox"/> Beach Towel	_____	_____
<input type="checkbox"/> Washcloth	_____	_____
<input type="checkbox"/> Sleeping Bag	_____	_____
<input type="checkbox"/> Pillow	_____	_____
<input type="checkbox"/> Pillowcase	_____	_____
<input type="checkbox"/> Laundry Bag	_____	_____
<input type="checkbox"/> Other	_____	_____

### PERSONAL HYGIENE ITEMS

	#	Brand & Color
<input type="checkbox"/> Razor	_____	_____
<input type="checkbox"/> Shaving Cream	_____	_____
<input type="checkbox"/> Hairbrush	_____	_____
<input type="checkbox"/> Shampoo	_____	_____
<input type="checkbox"/> Conditioner	_____	_____
<input type="checkbox"/> Soap	_____	_____
<input type="checkbox"/> Deodorant	_____	_____
<input type="checkbox"/> Toothbrush	_____	_____
<input type="checkbox"/> Toothpaste	_____	_____
<input type="checkbox"/> Sunscreen	_____	_____
<input type="checkbox"/> Insect Repellent	_____	_____
<input type="checkbox"/> Day Diapers	_____	_____
<input type="checkbox"/> Night Diapers	_____	_____
<input type="checkbox"/> Sanitary Napkins	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Other	_____	_____

### OTHER MISC. ITEMS

<input type="checkbox"/> Books	_____	_____
<input type="checkbox"/> Toys	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> 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.**