



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!



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 LIST 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 DIAGNOSIS: _____

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*

- | | | | | |
|---|--|--|---|--------------------------------------|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Crutches | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Eye Glasses | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Orthopedic Corrective Equipment | | |
| <input type="checkbox"/> Catheter Equipment | <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> BiPAP or CPAP | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> GPS Locator |
| <input type="checkbox"/> G-Tube | <input type="checkbox"/> Vagal Nerve Stimulator/Magnet | <input type="checkbox"/> Oxygen | <input type="checkbox"/> 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 ACTIVITIES 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 BEHAVIORS, UP TO AND INCLUDING PREDATORY AND/OR LIKE VICTIM-LIKE BEHAVIORS? _____

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 SWIM 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 THE PARTICIPANT'S ENVIRONMENT/FAMILY: _____

WILL PARENTS POSSIBLY BE ON VACATION DURING SESSION? YES NO

DOES PARTICIPANT KNOW? YES NO

IF YES, HOW CAN CAMP ALTITUDE 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



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:

(Check, if applicable, giving approximate dates)

- | | | | |
|--------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Legs | <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Breathing | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Vision | <input type="checkbox"/> Communication | <input type="checkbox"/> Social Adjustment |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Trunk | <input type="checkbox"/> Coordination | <input type="checkbox"/> Understanding | <input type="checkbox"/> Other |

HEALTH HISTORY

(Check, if applicable, giving approximate dates)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles (Rubella) | <input type="checkbox"/> Mononucleosis |
| | | | <input type="checkbox"/> 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 _____
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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	Diphtheria Pertussis Tetanus	Measles Mumps Rubella	Hepatitis	Pneumococcal	TB Test Given
<input type="checkbox"/> 2-4 months <input type="checkbox"/> 15 months <input type="checkbox"/> 5 years <input type="checkbox"/> Other Date _____	<input type="checkbox"/> 2-4 months <input type="checkbox"/> 6 months <input type="checkbox"/> 18 months <input type="checkbox"/> 5 years Date _____	<input type="checkbox"/> 12-15 months <input type="checkbox"/> 11-12 years <input type="checkbox"/> Other Date _____	<input type="checkbox"/> Hep A Date _____ Date _____ <input type="checkbox"/> Hep B Date _____ Date _____	Date _____ Date _____ Date _____	<input type="checkbox"/> TB Test Given Date _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive

Licensed Physician Signature: _____ Phone: _____

Address: _____ 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: _____

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	
<input type="checkbox"/> Hay Fever <input type="checkbox"/> Poison Ivy <input type="checkbox"/> Insect Stings <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Drugs Date _____ Date _____	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Asthma Date _____ Date _____	<input type="checkbox"/> Mononucleosis <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease Diabetes <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Hypertension <input type="checkbox"/> Seizures 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 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 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 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 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: 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.