Dear Summer Program Applicant:

Baddour’s 2017 YOUR Summer Program is an opportunity for The Baddour Center to partner with parents/family members of persons with intellectual disabilities to provide a unique respite.

The program will be offered Sunday through Friday for four different sessions during the summer of 2017. It is open to individuals with intellectual disabilities between the ages of 16 and 35. The sessions are designated by gender, and the cost for the program is $700 for the week. An initial $150 non-refundable deposit is expected at the time the application is completed. The remaining $550 is due upon registration.

The session dates are as follows:

- **Week 1** (male participants)    June 4–9, 2017
- **Week 2** (female participants)   June 11–16, 2017
- **Week 3** (male participants)   June 25–30, 2017
- **Week 4** (female participants)       July 9–14, 2017

In order to meet the needs of each applicant and to ensure the program creates memories that will last forever, we ask you to take some time to review the application and make every effort to answer each question. The more information we have about each applicant, the better the experience and our ability to meet individual needs.

- Please note the application with all supporting documents should be completed by April 28, 2017.
- We will notify you to confirm your scheduled session after the deadline passes.

Please don’t miss this opportunity to make new friends, tap into unique talents, and to be challenged by exciting activities all the while making memories. Should you have any questions, please feel free to contact me at 662-366-6928 or send me an e-mail at summerprogram@baddour.org.

I look forward to hearing from you and hope to see during the summer of 2017!

Sincerely,

Cassie Smith
Resident Recruitment and Admissions
2017 Summer Program Application

Please print

Date: ______________________________________________________________________________________________________

Full Name of Applicant: _______________________________________________________________________________________

Address: __________________________________________________________________________________________________

City:________________________________________________________ State: ____________________Zip: ________________

Telephone:   ________________________________________   Gender: _________________________ ____________________

Applicant’s Date of Birth: ________________________________ Current Age:  __________________________________________

Height:  ____________________________ Weight:  ______________  Eye Color: _______________ Hair Color:  _______________

T-Shirt Size: ________________________

Parent/Guardian Information

Name of Parent/Guardian:_____________________________________________________________ _________________________

Relationship to Applicant:  _____________________________________________________________________________________

Home Phone: _________________________________________________________________________________________ _______

Work Phone: ________________________________________________Cell Phone: _______________________________________ 

Email address: _______________________________________________________________________________________________

Place of Employment:  ________________________________________________________________________________________

How did you hear about The Baddour Center’s summer program?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Please indicate your preferred session: __ June 4-9 (M) __June 11-16 (F) __ June 25-30 (M) __ July 9-14 (F)
Emergency Contact Information

The Baddour Center will always contact parents/guardians first; however, in the event of an emergency and they cannot be reached, please provide the following information for others we may contact (grandparents, siblings, neighbor).

**Primary Contact Name:** ____________________________________

Relationship to Applicant: ____________________________________

Home Phone: ____________________________________

Cell Phone: ____________________________________

Place of Employment: ____________________________________

Work Phone: ____________________________________

Email address: ____________________________________

**Secondary Contact Name:** ____________________________________

Relationship to Applicant: ____________________________________

Home Phone: ____________________________________

Cell Phone: ____________________________________

Place of Employment: ____________________________________

Work Phone: ____________________________________

Email address: ____________________________________

**Additional Contact Name:** ____________________________________

Relationship to Applicant: ____________________________________

Home Phone: ____________________________________

Cell Phone: ____________________________________

Place of Employment: ____________________________________

Work Phone: ____________________________________

Email address: ____________________________________

**Name(s) of Siblings:** ____________________________________
Educational and Social Information

Please list the name of the most recent school, training program and or residential enrollments in which the applicant is currently participating or participated in the past.

Name of school/program: _______________________________________________________________________________________
Dates: ____________________ Reason for leaving (if applicable): _______________________________________________________________________________________

Please provide answers to the following in order to assist The Baddour Center staff in better serving your loved one.

Describe the applicant’s favorite hobbies, interests, and forms of entertainment: __________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Describe the applicant’s current fitness routine and/or level of participation in fitness activities, as well as any extra support needed:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Describe how the applicant socializes and/or relates with peers: _______________________________________________________
____________________________________________________________________________________________________________

Does the applicant have a history of aggressive or threatening physical or verbal behavior? If so, state in your own words the nature of the behavior, possible causes, possible triggers and consequences. ____________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Describe any nutritional needs (any foods that he/she cannot or will not eat, etc.): __________________________________________
____________________________________________________________________________________________________________

Is there anything we need to know (fears, need for structure/routine, sensory needs, difficulty transitioning, etc.) to ensure YOUR Summer Program is a positive experience for your loved one? ______________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Please submit your most recent psychological report. It must have been completed within the last 4 years.
## Activities of Daily Living

Please describe the applicant’s level of independence in regard to each of the following activities of daily living:

<table>
<thead>
<tr>
<th>ADL</th>
<th>Independent?</th>
<th>What assistance, if any is required?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
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<tr>
<td>Communicating (needs and wants)</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Mobility</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Showering/Bathing</td>
<td>Yes/No</td>
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<tr>
<td>Dresses Self</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Bowel Management</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Bladder Management</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Oral Hygiene</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Follows Instructions/directions</td>
<td>Yes/No</td>
<td></td>
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<tr>
<td>Keeps personal space neat</td>
<td>Yes/No</td>
<td></td>
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</tbody>
</table>

Please describe the applicant’s sleeping habits (i.e., light vs heavy sleeper, requires a nightlight, noise machine, going to bed routine).

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

The Baddour Center is a tobacco and alcohol free campus, and these products are prohibited on our campus.
Medical Information

1. Does the applicant have allergies? □ Yes    □ No
   If yes, what type (food, medicine, insect stings, hay fever, animals): _____________________ Please describe most recent allergic reaction: ______________________________

2. Is the Applicant currently subject to seizures? □ Yes    □ No

3. If the Applicant is currently subject to seizures, please identify:
   Type of seizure: ______________________________________________________
   How often do they occur: _______________________________________________
   Date of Last seizure: ________________________________
   Limitations or risks that may result from a seizure: ______________________
   Possible triggers, causes or strategies that may be helpful to staff:

4. Does the Applicant have problems with vision? □ Yes    □ No

5. Does the Applicant wear glasses and/or contacts? □ Yes    □ No

6. Does the Applicant have a hearing impairment? □ Yes    □ No

7. Does the Applicant wear a hearing aid(s): □ Yes    □ No
   If yes, please specify: □ bilateral □ Left Ear □ Right Ear

8. Has the applicant ever been hospitalized □ Yes    □ No
   If yes, reason and date of hospitalization:

9. Does the applicant have chronic/recurrent illnesses □ Yes    □ No
   If yes, what is the illness and best treatment method:
Medications

If the applicant takes medications, bring enough medication to last the entire time of the program. Over the counter medication brought for the week must be in original containers with labels. Prescription medications must be in original containers with labels that show the applicants name and how the medication should be given.

List all prescribed medications being taken during summer program and reasons:
1. Name of Medication: ____________________________________________________________________________________
   Dosage requirements/frequency: ___________________________________________________________________________
   Reason for medication: ____________________________________________________________________________________

2. Name of Medication: ____________________________________________________________________________________
   Dosage requirements/frequency: ___________________________________________________________________________
   Reason for medication: ____________________________________________________________________________________

3. Name of Medication: ____________________________________________________________________________________
   Dosage requirements/frequency: ___________________________________________________________________________
   Reason for medication: ____________________________________________________________________________________

4. Name of Medication: ____________________________________________________________________________________
   Dosage requirements/frequency: ___________________________________________________________________________
   Reason for medication: ____________________________________________________________________________________

The following non-prescription medications may be stocked in the first aid supplies and are used on an as needed basis to manage illness and injury. Check those that the camper can be given:

☐ 1. Ibuprofen (Advil, Motrin)
☐ 2. Tylenol
☐ 3. Phenylephrine TCI nasal decongestant tablets
☐ 4. Cough drops
☐ 5. Benadryl
☐ 6. Imodium

Please list any other over-the-counter medications that have proven effective in treating minor health issues or injury of the applicant:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
### ADDITIONAL APPLICANT MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Allergies or Hay Fever</td>
<td></td>
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<tr>
<td>Anemia (i.e., low iron)</td>
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<tr>
<td>Anxiety or Panic Attacks</td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Attention deficit/hyperactivity disorder</td>
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<tr>
<td>Back Problems</td>
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<tr>
<td>Balance Problems</td>
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<tr>
<td>Bone or Joint Disease</td>
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<tr>
<td>Bowel or Colon Disease</td>
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<tr>
<td>Broken or Cracked Bones</td>
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<tr>
<td>Concussion or Head Injury</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Emotional/Mental health concerns</td>
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<tr>
<td>Fainting</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Heart Murmur or Heart Disease</td>
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<td></td>
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<tr>
<td>Hepatitis</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>History of “faking” health issues</td>
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<tr>
<td>Lung Problems</td>
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<td></td>
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<tr>
<td>Menstrual problems</td>
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<tr>
<td>Muscle Disease or Weakness</td>
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<tr>
<td>Neurological Disorders</td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Dystonia</td>
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<tr>
<td>Psychiatric/psychological counseling</td>
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<tr>
<td>Psychiatric hospitalization</td>
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<tr>
<td>Skin Disease – Chronic</td>
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<tr>
<td>Skin Infections – Recurrent</td>
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<td>Sleep Difficulties or Disorders</td>
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<tr>
<td>Sinus Problems</td>
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<tr>
<td>Speech Disorder</td>
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<tr>
<td>Sprains or Dislocations</td>
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<tr>
<td>Swallowing Difficulty</td>
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<tr>
<td>Stroke or TIA</td>
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</table>

### IMMUNIZATION HISTORY

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis B Series</td>
<td></td>
<td></td>
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<tr>
<td>Influenza</td>
<td></td>
<td></td>
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<tr>
<td>Tetanus</td>
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<tr>
<td>PPD/TB skin test</td>
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</table>

**DATE OF LAST SHOT:**
- Hepatitis B Series: [Date]
- Influenza: [Date]
- Tetanus: [Date]
- PPD/TB skin test: [Date]
Insurance Information

Copies of the Applicant’s insurance identification cards must be provided at the time of registration. A representative of The Baddour Center will provide the Applicant’s insurance information as appropriate to Health Care Providers if necessary. However, following up on any discrepancies in the filing of claims, billing, or charges is the responsibility of the Applicant’s family.

List all insurance providers, policy numbers and dates of coverage:

Private Health Insurance: ______________________________________________________________________________________
__________________________________________________________________________________________________________

Medicare Number: ___________________________________________________________________________________________

If the Applicant is receiving Medicare benefits, please check all that apply:
☐ Part A (Hospital)  ☐ Part B (Medical)

Medicaid Number: ___________________________________________________________________________________________

State in which Medicaid is received: ___________________________________________________________________________

Prescription Drug Plan: _______________________________________________________________________________________
Physical Evaluation

Name of Applicant: ___________________________________________________________

Date: _______ Age: _______ Sex: _______ Wt: _______ Ht: _______ BP: _______

Allergies (food or drug): ___________________________________________________

___________________________________________________________________________

History: ___________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

General Appearance:

Eyes: ___________________________ Ears: ___________________________

Nose: __________________________ Skin: __________________________

Mouth: __________________________ Neck: _________________________

Chest: __________________________ Breasts: _______________________

Lungs: __________________________ Heart: _________________________

Abdomen: ________________________ Primary diagnosis: __________________

Description of specific physical impairments, physical limitations or orthopedic impairments:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
List current medications: ____________________________________________________________

______________________________________________________________________________

Impressions and recommendations: ________________________________________________

______________________________________________________________________________

______________________________________________________________________________

The following screening is required prior to attending the summer program. Give date and results.

PPD: _______________________________________________________________________

Physician’s Name (Please Print or Stamp)

______________________________________________________________________________

Physician’s Signature

______________________________________________________________________________

Address

______________________________________________________________________________

City, State, Zip

______________________________________________________________________________

Phone Number
Consent and Agreement Form

Medical Care, Medications and Procedures: I/We give permission for licensed nursing personnel to administer prescribed and over-the-counter medications and procedures consistent with the licensure of such nursing personnel as required and as reviewed by physician’s orders, including but not limited to the treatment of the common cold, sinus infection, constipation, headache, etc.

Applicant’s Name: _________________________________________________________________________

Signature of Parent/Guardian: _______________________________________________________________________

Photographic Release: I/We hereby give our consent to Y.O.U.R. Summer Program to photograph and/or make video or audio recordings of the above named applicant without limitation and to use such photographs, videotapes or audiotapes and the applicant’s name, likeness, and voice and related stories in connection with any of the work, programs, projects, fundraising or other endeavors of Y.O.U.R. Summer Program in any and all media, including electronic or digital.

Applicant’s Name: _________________________________________________________________________

Signature of Parent/Guardian: _______________________________________________________________________

Personal Property: I/We recognize that Y.O.U.R. Summer Program does not accept any responsibility for the care and safekeeping of the clothing and other personal property of the above name applicant. I understand that any items the applicant brings to the program (including, but not limited to cameras, cell phones or expensive clothing) are the responsibility of the applicant.

Applicant’s Name: _________________________________________________________________________

Signature of Parent/Guardian: _______________________________________________________________________

Swimming Consent: I/We hereby request that my applicant be allowed to participate in swimming and other water activities offered to the participants in the summer program. **I/We have been informed and understand should the applicant have an active seizure disorder, The Baddour Center reserves the right to restrict/deny access to swimming. Baddour also reserves the right to deny access to swimming and any water activities if determined the safety of the applicant or the safety of other participants/staff could be compromised.**

Applicant’s Name: _________________________________________________________________________

Signature of Parent/Guardian: _______________________________________________________________________
Please attach a recent photograph