BRAIN INJURY ASSOCIATION
OF NORTH CAROLINA

15th Annual BIANC Retreat

Hosted by The Brain Injury Association of North Carolina

- **WHEN**: **September 11-13, 2009**
- **WHO: Survivors of Brain Injury, family members and friends**
- **WHAT: A weekend of camp, fun and fellowship for survivors.**
- **WHERE: Camp Carefree-Stokesdale, NC**
- **WHY: To have fun!**
- **HOW: Campers, Caregivers/Family members complete the registration forms and send to BIANC with a check for $20.00 per person payable to BIANC. ($18.00 for BIANC members) You will receive a confirmation on your registration with directions, schedule and what to bring.**

BIANC
PO Box 10912
Raleigh, NC 27605

Please carefully read the enclosed application forms. Forms must be filled out for each person attending camp, including caregivers/family members. If you need multiple applications, please feel free to photocopy any forms provided.
Horse Back Riding: EVERY person that wants to participate in the horseback riding must have Pages 7 & 8 completed by a physician.

For information regarding registration or BIANC membership, please call the Raleigh BIANC office at
(919) 833-9634 or 1-800-377-1464
bianc@bianc.net

The deadline for all applications is August 11, 2009!

If forms are incomplete, they will be returned to you.

BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

CAMP APPLICATION

Please complete one form for each person attending this BIANC event.
***Deadline for registration* is 4 weeks before the event. (August 11, 2009)**
Please get applications in as soon as possible as space is limited!

Application Date:___________________ **Camp Date: September 11-13, 2009**

Name: (Last)_____________________**(First)**_________________**(Nickname)**___________

Check the box that applies to you:

- ❑ **Survivor of BI and their Caregiver/Family**
- ❑ **Caregiver for:**____________________________
- ❑ **Volunteer Professional:** _____________________________
  (Name profession above)
- ❑ **Student:**_______________________________
  (Name major above)
- ❑ **Special Sleeping Needs**: Examples: Couples, need electrical outlet by bed, anyone you specifically need to be with in same cabin. If yes, please explain on back of this form.

Address:___________________________**City:**________________________

State:___________________**Zip Code:**____________________

Telephone: (Day)_________________**(Night)**_______________**(Cell)**________________

Age:_______**Date of Birth:**____________________**Gender: Male Female**

Email Address:___________________________________

Emergency Contact During Camp; Name:__________________________________

Contact's Telephone:
(Day)________________**(Night)**_____________**(Cell)**_________________

T-Shirt Size: Medium Large XLarge XXLarge XXXLarge

In planning for camp we seek to provide the highest level of care and safety possible. In order to do this we need to know as much information as possible about the functional levels and specific needs. Please provide all information that might be of value to camp staff working with the applicant during the event. **All applicants**, please fill out the application in its entirety. Regardless of how many years you have attended camp, we want the most accurate information to ensure a safe and fun event for everyone.

Official Use Only

Received______ Payment______ Notified_________
Check#_________ Amount_________

Medical Information

All medical information must be complete before application will be processed.

Medical History:
Please list all current and prior pertinent conditions and surgeries.

Diagnosis	Date	Surgery	Comments
Ex. Brain Injury	10/15/1979	Shunt put in	Protect shunt site, headaches
Ex. Diabetes	6/7/1982		Food restrictions

Please list all doctors currently treating applicant

Name	Specialty	Phone	After Hours #

Seizure History:
Does this applicant have a history of seizures? ☐ Yes ☐ No
If Yes, what type?_______________How often____________Date of most recent seizure______________
Are there any “auras” or behaviors/events that occur before or after seizure takes place?

Medications:

Is the applicant capable of administering his/her own medication? Yes No

ALL MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION PACKING/BOTTLE

Please document all medications applicant will take during the time they are at camp:

Medication	Dosage	Times Administered	# of pills per dose	Pill Color	Special Instructions	Purpose of Medication
Ex. Klonopin	1mg	9am,3pm	1	Blue	Crushed in applesauce	Anxiety

Are there any known allergies? (Including food, insects, medications, etc.)
☐ No ☐ Yes If yes state allergy and nature of reaction and treatment:

Are there any special precautions that should be taken for the applicant? ☐ No ☐ Yes
If yes, describe in detail.

Are there particular habits/concerns the camp staff should be aware of (food dislikes, sleeping patterns, wandering, inappropriate language or behavior)?
While at camp there will be male and female volunteers as well as campers. Does the applicant have difficulties with maintaining appropriate male/female relationships? If so, explain.

Please indicate any problem areas for the applicant (check all that apply)
_______ Paralysis ______Short term memory_______Vision_______Hearing ________Agitation
_______Attention span_______ Behavioral______Speech

Please note any further information we may need to know about any of these problem areas.

Does the applicant use any of the following:______Cane _______ Leg Braces _______Walker
________ Wheelchair
If the applicant uses a wheelchair, which type? _______ Manual _________ Power

Can the applicant propel indoors/outdoors independently? _______ Yes ________ No
If no, what assistance may be required?

Is the applicant able to transfer him/herself from chair to bed, bath, or toilet?_______ Yes _________ No
If no, what assistance is required?

Do you have any special dietary needs the MUST be met at camp? _________Yes __________No

Do you have a service animal that will be accompanying you to camp? _________Yes ________No
***If yes you must provide a copy of certification of service animal and current immunizations when you submit this application.**

Please address the following if applicable; provide details and strategies that may be helpful to staff in interacting with the applicant.

Cognitive Issues:

Physical Issues:

Emotional Issues:

Communication Issues:

Please indicate the level of assistance the applicant requires for each of the following:

Level of Assistance	None	Minimal	Moderate	Total
Activity				
Dressing/Undressing				
Eating				
Toileting				
Bathing/Hygiene				
Walking				

The Following Sections Must Be Completed

In the event that my emergency contact cannot be reached in an emergency, I hereby give permission to the camp director to make arrangements for hospitalization and to secure proper treatment from a licensed medical professional for___________________________________.
Applicant's Full Name

_________________________________ _______________________________
Signature of Applicant Date

_________________________________ _______________________________
Signature of parent/guardian Date

I hereby acknowledge that I am fully aware of the risks involved in participating in the activities at this BIANC event and have taken into account the abilities of _________________________
With respect to making decisions to participate in the program. I hereby release BIANC, its volunteers and agents from any and all claims of any nature arising out of participation in this camp.

__________________________________ _______________________________
Signature of Applicant Date

__________________________________ _______________________________
Signature of parent/guardian Date

At various times during camp, print and television media will be invited to camp. In addition BIANC may develop video or photographic displays of individuals and the camp. Please indicate your preference:
DO DO NOT film or photograph___________________________ for public purposes.
Applicant's Full Name

__________________________________ _______________________________
Signature of Applicant Date

__________________________________ _______________________________
Signature of parent/guardian Date

While in attendance of this BIANC event, I am aware that there is to be no use or possession of alcohol, drugs, illegal substances, weapons, or anything that may be seen as offensive to others. I am aware that everything that I do while participating in this event is a reflection of BIANC. With that in mind I am aware that all decisions made by the camp director are final and all rules will be enforced. I am aware that if I do not conduct myself in a way that is a positive reflection on BIANC and its values, I may not be allowed to participate in this even

__________________________________ _______________________________
Signature of Applicant Date

________________________________ _______________________________
Signature of parent/guardian Date

HorsePOWER

ALL camp participants **MUST** complete the attached forms in order to participate with the horseback riding activities.

Those camp participants who do not have a completed:

HorsePOWER Form
Rider's Medical History
Physician's Statement
CANNOT ride on a horse.

I hereby acknowledge that I have been advised of the risks involved in participating in the activities sponsored by the Brain Injury Association of North Carolina. I also acknowledge that I have taken into account the impairments (if applicable) of ________________________________
Participant's Full Name
And hereby release BIANC, its volunteers and agents form any and all liability/claims of any nature arising out of participation in this retreat.

____________________________________ ____________________________________
Signature of Participant Date

____________________________________ ____________________________________
Signature of parent/guardian Date

____
Signature of Witness
(To be signed at registration/check-in)

Rider's Medical History and Physician's Statement

(To be completed by physician in order to participate in horse riding activities at camp)

Name:______________________________ Date of Birth:____________________________

Address:____

Name of Parent/Guardian:____

Diagnosis:_________________________________ Date of onset:___________________________

**For Persons with Down Syndrome:
Cervical X-ray for atlantoaxial Instability: ________Positive______Negative X-Ray date__________

Tetanus Shot: Yes No Date_____________ Height__________ Weight__________

Seizure Type______________ Controlled___________ Date of last seizure_________________

Please indicate if patient has a problem and /or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation_______ Yes______ No Crutches ______Yes________ No
Braces________ Yes_______ No Wheelchair ______ Yes _______No

Please indicate any special
precautions:____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh in the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities limitations by a licensed/credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print)____

Physician Signature____

Address________________________ City_______________State________ ZipCode_________

Phone________________________ Date____________________________

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form please note whether these conditions are present and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Sublaxation and disclocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical
Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to spinal cord injury
Seizure Disorders

Secondary Concerns
Behavior problems
Age under two years
Age under four years
Acute exacerbation of chronic disorder
Indwelling catheter