NEEDS ASSISTANCE FORM
2021 Season

NAME: _____

Please mark the areas you require assistance using the following:

I=Independent
SA=Some Assistance
TA=Total Assistance
NA= Not Applicable

	I	SA	TA	NA	Special Instructions
Cathing	☐	☐	☐	☐	_____
Irrigating	☐	☐	☐	☐	_____
Transferring	☐	☐	☐	☐	_____
Dressing	☐	☐	☐	☐	_____
Shower/Bathing	☐	☐	☐	☐	_____
Bracing	☐	☐	☐	☐	_____
Wheeling/Walking	☐	☐	☐	☐	_____
Taking Medications	☐	☐	☐	☐	_____

List Allergies:
Allergy

Please send medications required for treatment
Treatment at home for reaction

_____ _____

_____ _____

Cathing Schedule: (Times) _____

Skin Breakdown: PLEASE BRING SUPPLIES WITH YOU TO CARE FOR ANY BREAKDOWN (TAPE, GAUZE PADS, OINTMENT, BANDAIDS, ETC.)

Does participant have any skin problems _____ Yes _____ No

Where is the sore located: _____

How is the area being treated: _____

PRN MEDICATIONS

Antacids: YES OR NO Anti-Diarrheal: YES OR NO Benadryl: YES OR NO

Bug Spray: YES OR NO Ibuprofen: YES OR NO Pepto-Bismol: YES OR NO

Sunscreen: YES OR NO Triple Antibiotic Ointment: YES OR NO Tylenol: YES OR NO

Other: _____

Please list all medications

Please bring your meds pre dosed! For pills, medicine bags or pill boxes are preferred. For liquid, we suggest syringes with caps. Liquids do need to be dosed out. Dosing liquid meds is new to camp, but now necessary. Please remember your meds. If you do not bring them, for your safety we cannot allow you to stay. For the occasional headache, temperature, sore throat, etc. please bring an over the counter medication(s) to treat these symptoms.

List medications:

Prescription & Non-Prescription	**Dosage** (mg)	**Form** Pill/Liquid	**Times** M	Noon	A	D	B	**Purpose**	**Description of Pill(Medication)**

Please list food restrictions: _____

Please list emergency contact name and telephone number (including yourself-parents):

	Contact Name	**Telephone Number**	**Email**
1.			
2.			

I/We have reviewed the above information and made any necessary modifications. The information contained on this form is current and accurate. Furthermore, I/We assume all risk associated with participating in recreational activities and use of the facilities and amenities at Camp Guyasuta. I agree to hold harmless and indemnify the SBAWP and its employees, and do hereby release and forever discharge SBAWP and its employees from all liability, causes of actions, suits, debts, damages, claims, or demands of any nature whatsoever which may arise in connection with me/my child participating in any activity while at the Firefly Camps and Retreats program. The terms hereof serve as a release and assumption of risk for my heirs, estate and all members of my family. I/We understand that the Firefly Camps and Retreat staff ***ARE NOT*** responsible for the dosing of medications, therefore, I agree to provide all medications pre-dosed in an appropriate container. I/We also understand that the Firefly Camps and Retreat staff ***ARE NOT*** responsible for lost or damaged items.

_____

Parent/Guardian/Participant (18 years old or older) Date- 2021

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Firefly Camps & Retreats
A Time to Grow ... ... A Chance to Glow
Spina Bifida Association of Western Pennsylvania