

NEEDS ASSISTANCE FORM

FireFly Camps and Retreats 2022



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irrigating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shower/Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bracing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheeling/Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

List Allergies:

Please send medications required for treatment

Allergy

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 <input type="checkbox"/> NO <input type="checkbox"/> | Anti-Diarrheal: YES <input type="checkbox"/> NO <input type="checkbox"/> | Benadryl: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Bug Spray: YES <input type="checkbox"/> NO <input type="checkbox"/> | Ibuprofen: YES <input type="checkbox"/> NO <input type="checkbox"/> | Pepto-Bismol: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Sunscreen: YES <input type="checkbox"/> NO <input type="checkbox"/> | Tylenol: YES <input type="checkbox"/> NO <input type="checkbox"/> | Antibiotic Ointment: YES <input type="checkbox"/> NO <input type="checkbox"/> |

Other: _____

*****Please list all medications*****

Medication MUST be pre-dosed. For pills, medicine bags or pill boxes. For liquids, syringes with caps. Please bring any over the counter medication(s) if necessary.

List medications:

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

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

ADULTS	FOR STAFF USE ONLY	YOUTH & TEEN
Retreat 1: Initial _____ Date _____	Retreat 1: Initial _____ Date _____	Retreat 1: Initial _____ Date _____
Retreat 2: Initial _____ Date _____	Retreat 2: Initial _____ Date _____	Retreat 2: Initial _____ Date _____
Camp: Initial _____ Date _____	Camp: Initial _____ Date _____	Camp: Initial _____ Date _____
Retreat 3: Initial _____ Date _____	Retreat 3: Initial _____ Date _____	Retreat 3: Initial _____ Date _____
Retreat 4: Initial _____ Date _____	Retreat 4: Initial _____ Date _____	Retreat 4: Initial _____ Date _____