Dear Prospective C.A.M.P. University Family:

We at C.A.M.P. University take a deep interest in ensuring that we can satisfactorily meet the needs of candidates who are being considered for admission to our Day Program. We want our campers to have a fun and enjoyable experience. We appreciate the time and effort needed to complete this application, and we are always willing to help you through this process should you require assistance. If you have any questions, please contact C.A.M.P. University at 956-800-5292.

Please return the completed application along with the required documents to C.A.M.P. University at 4200 N. Main St. in McAllen, or mail to P.O. Box 2294, McAllen TX 78502. After we have received these materials, our Admissions Committee will review the information and determine the suitability and placement of the potential candidate as a member of C.A.M.P. University. Once the application is reviewed we'd like to invite your student to attend C.A.M.P. University for three days as our guest. Please call our office at 956-800-5292 to make arrangements.

Thank you for your interest in C.A.M.P. University. We hope that we can be of service to you.

Sincerely,

Abbie Sasser
C.A.M.P. University Founder and Board Member

C.A.M.P. University does not discriminate on the basis of race, color, ethnicity, religion, age, or gender in its admissions policies or programs.

C.A.M.P. University Admission Documents Checklist

Please include the following documents:

- ☐ Completed Admission Application
  Date turned in to office: ________________

- ☐ Current psychological evaluation from High School records (if available)
  (Wechsler Intelligence Scale, Vineland Testing, etc.)

- ☐ Current medical physical (Special Olympics Athletic Medical Form and a current TB skin test or chest x-ray)
  *Please note: we require the physical to be redone every three years whether or not your loved one participates in Special Olympics. This is for their safety.

- ☐ Current list of medications (pg 25)

- ☐ Immunization Records (if possible)

- ☐ Completed Signature on:
  Photo use consent form
  Parental consent waver form for field trips
  Hold harmless agreement
  Transportation liability release form

- ☐ Completed authorization form for background check (Please have you driver's license and social security card so we can make a copy for the background check.)

- ☐ Completed automatic draft form

For Office Use Only

Dates of trial days: ____

Date of director and board approval: ______________________________

Application for Admission

(Please Print or Type)

Date: ________________________ Desired Date of Admission: ______________________

Past involvement with C.A.M.P. University ____

____

How did you become aware of C.A.M.P. University? __________________________________

____

Candidate Information

Name: ____

Phone: ____

Address: ____

Date of Birth: __________________________ Place of Birth: _________________________

Social Security Number (last four digits) _ _ _ _

Gender: __________ Race: ____________ Height: ___________ Weight: ____________

Primary language: _______________ Secondary language(s): ___________________________

Diagnosis (es): ____

____

Briefly describe any physical disabilities or limitations that the admissions candidate may have:

____

____

Candidate's desired areas for improvement: ______________________________________

____

Candidate's personal goals: ______________________________

____

____

____

Sponsor's goals/expectations for the candidate: ______________________________

____

____

____

Parent/Guardian Contact Information

Name: ______________________________ ______________

Home Phone: ______________ Business Phone: ______________

Business Address: ______________ ______________

Email: ______________________________

Home Address: ______________________________

Relationship to Candidate: ______________________________

Employer: ______________________________

Title: ______________________________

Emergency Contact Information

Primary Contact: ______________________________

Home Phone: ______________________________

Business Phone: ______________________________

E-mail: ______________________________

Relation to Candidate: ______________________________

Mailing Address: ______________________________

Secondary Contact: ______________________________

Home Phone: ______________________________

Business Phone: ______________________________

E-mail: ______________________________

Relationship to Candidate: ______________________________

Mailing Address: ______________________________

Optional Family Information (e.g. relationship concerns, frequency of contact, etc.):

____

____

____

Candidate's Educational and Residential History

Please indicate each type of educational program in which the candidate has participated and provide the details for each in the spaces below. Elaborate as needed to illustrate achievements or to identify areas for improvement. Continue on additional sheets if necessary.

Educational Background

1. Name of school or program ______________________________

   Dates/years attended ______________________________

   If candidate is not currently enrolled in this program, please explain the reason for leaving.

   ____

   ____

   Briefly describe the candidate's overall educational experience with this program (strengths, areas for improvement, grades, etc.). ______________________________

   ____

   ____

2. Describe candidate's formal education and any trade, technical, or vocational training: _____

____

Employment History

Please complete this section of the application to describe all past employment by the candidate.

1. Employer's name: ______________________________

   Job/duties performed: ______________________________

   ____

   Dates of employment: ______________________________

   Reasons for leaving: ______________________________

2. Employer's name: ______________________________

   Job/duties performed: ______________________________

   ____

   Dates of employment: ______________________________

   Reasons for leaving: ______________________________

If the candidate has not had a job, please let us know if they received any job skills training in school.

____

____

____

____

What is the candidate's dream job?

____

____

____

____

____

____

Candidate's Health

Please list the types of medical coverage that the candidate has and provide the corresponding policy numbers (Insurances, Medicaid, Medicare, VA, etc.):

Name of Provider	Policy Number	Expiration/Renewal Date
______________________	________________________	_______________
______________________	________________________	_______________

Name of Candidate's Primary Care Physician: ______________________________

Physician's Phone: ____

Address: ____

Special dietary needs:

____

____

Seizures:

Does the candidate have a history of seizures? ☐ yes ☐ no

If yes: Type of seizures (grand mal, petit mal, other): ________________________

Date of 1st seizure: ____________ Date of most recent seizure: _______________

Seizure frequency: ☐ daily ☐ weekly ☐ monthly ☐ semi-annually ☐ other

Are the seizures suppressed or controlled by prescribed medication(s)? ☐ yes ☐ no

Please list any limitations or risks that may result from a seizure: ________________

____

____

Candidate's Medical History

Please examine the list below and note candidate's experiences with any of these factors or conditions. If possible, note the year of occurrence and elaborate briefly on the severity or frequency of the condition.

Circle one		Condition	Year(s) Additional Description
yes	no	Speech disorders	
yes	no	High blood pressure	
yes	no	Heart problems	
yes	no	Diabetes	
yes	no	Cancer	
yes	no	Stroke	
yes	no	Kidney disease	
yes	no	Glaucoma	
yes	no	Arthritis	
yes	no	Sinus problems	
yes	no	Headaches	
yes	no	Hearing problems	
yes	no	Asthma	
yes	no	Digestive problems	
yes	no	Fainting	
yes	no	Balance problems	
yes	no	Menstrual problems	
yes	no	Muscular problems	

Circle one		Condition	Year(s) Additional Description
yes	no	Polio	
yes	no	Pneumonia	
yes	no	Anemia	
yes	no	Chicken pox	
yes	no	Mumps	
yes	no	High cholesterol	
yes	no	Measles	
yes	no	Pregnancy	
yes	no	Hepatitis	
yes	no	Thyroid problems	
yes	no	Venereal disease	
yes	no	Swallowing difficulty	
yes	no	Head injury	
yes	no	Depression	
yes	no	Use of prosthetics, canes, walkers, lifts, and other devices	

Other significant health concerns: ______________________________

____

____

Candidate's Religious Affiliations (optional)

Church/denominational preference: ______________________________

Other religious interests/activities: ______________________________

Candidate's Leisure and Recreation Interests

Hobbies: ____

Past Special Olympics activity: ____

____

Level of participation in the sports listed above: ______________________________

____

Assistance/Guidance needed for any recreational activities: ______________________

____

Favorite forms of entertainment: ______________________________________

____

Personal and Social Development

Reading, speaking, listening strengths: ______________________________

____

Reading, speaking, listening limitations: ______________________________

____

Does the candidate socialize well with others? ______________________________

How does he/she handle disagreements? ______________________________

____

Does the candidate have a history of aggression or threatening physical or verbal behavior?

☐ yes ☐ no If yes, please explain the frequency of this behavior, the possible causes/ environmental triggers, and the consequences of such activity. ______________

____

____

Does the candidate feel remorse for his/her aggressive or threatening behavior? ________

____

Activities of Daily Living

Can the candidate perform the following activities independently? If no, please include the level of assistance required (if applicable).

Mobility/ambulation: ______________________________

____

Communicating needs: ______________________________

____

Personal grooming and dressing: ______________________________

____

Orientation/Disorientation: ______________________________

____

Bowel and Bladder management: ______________________________

____

Eating: ______________________________

____

Social Étiquette (table manners/politeness) ______________________________

____

Awareness of time/day (clocks/calendars):______________________________

____

Use of public transportation: ______________________________

____

Cooking: ______________________________

____

Laundry and house cleaning: ______________________________

____

Managing personal finances: ______________________________

____

Guardianship Statement

Complete either Section I or Section II below:

Section I

Attached is a copy of a court-executed guardianship order declaring ______________________________ to be the lawful guardian(s) of ______________________________.

______________________________	______________________________
Guardian/Sponsor Printed Name	Candidate Printed Name
______________________________	______________________________
Guardian/Sponsor Signature & Date	Candidate Signature / Date

Section II

I know of no court-executed guardianship order for ______________________________.

______________________________	______________________________
Guardian/Sponsor Printed Name	Candidate Printed Name
______________________________	______________________________
Guardian/Sponsor Signature & Date	Candidate Signature / Date

Affirmation of Completeness and Accuracy of Application

Guardian/Sponsor: After you have provided the above information, please read the following statement and sign where indicated:

I/We, ______________________________, hereby affirm that the information provided within the completed application is complete and accurate to the best of my/our knowledge.

______________________________	______________________________
Guardian/Sponsor Printed Name	Candidate Printed Name
______________________________	______________________________
Guardian/Sponsor Signature and Date	Candidate Signature and Date (if appropriate)

C.A.M.P.
UNIVERSITY

Transportation Liability Release Form

I, ____, **being 21 years of age or older**, do for myself and do hereby release, forever discharge and agree to hold harmless

(Name of Group) C.A.M.P. University and **(Trip Organizer)** C.A.M.P. University Staff

Transportation Volunteers

and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damages and expenses, of any nature whatsoever which may be incurred by the undersigned that occur while said is participating in the above described transportation services, trip or activity.
Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and any related activities involved therein.
The undersigned further hereby agrees to hold harmless and indemnify said organization(s), its directors, employees and agents, for any liability sustained by said travel organizers as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

Participant Signature

____

Trip Participant Acknowledgement

I was provide and have read the above and understand the Rules of Conduct and will fully abide by them, as well as all additional instructions of the leadership of this trip, and activity directors.

This agreement is for any and all field trips organized by C.A.M.P. University

____

____

Parent or Legal Guardian

C.A.M.P. UNIVERSITY

Parental Consent & Waiver form for Field Trips

Permission is granted or my son/daughter to participate in the following field trip with C.A.M.P. University
Name: ____

I/We, hereby acknowledge that sufficient information has been provided by the C.A.M.P. University School with respect to planned activity, duration, location, method of transportation, participants and supervision.

I/We, hereby acknowledge that certain RISKS OF INJURY are inherent to participate in learning activities outside the school. These types of injuries may be minor or serious and may result from one's actions, or the actions or inaction of others, or a combination of both.

I/We understand that the Rules and Regulation established for the field trip are designed for the safety and protection of the participants and herby undertakes to inform my child to abide by these rules and regulations.

I/We understand that:

1. A minimum level of fitness and health (physical, mental and emotional), is required
2. Each person has a different capacity for participation: and
3. Any exceptions to full participation are identified on the Child Health Form.

I/We declare having read and understood the above Parental Consent Agreement in its entirely and hereby consent to allow my/our young adult to participate, acknowledging all of the foregoing.

______________________________	____________	________________
Parent or Legal Guardian Signature	**Date**	**Phone Number**

______________________________	______________________________
Emergency Contact	**Phone Number**

C.A.M.P.
UNIVERSITY

Hold Harmless Agreement

The following named is a participant in C.A.M.P. University, (I, We) agree to hold C.A.M.P. University harmless from any losses to the participant or family member, physical, mental or financial which claims could arise at any time or place C.A.M.P. University has an activity or as a result of any activity or meeting.

It is further understood that C.A.M.P. University is to be held harmless for any and all claims which could be entered for sexual abuse and or sexual harassment as a result of activities or meeting associated with C.A.M.P. University.

It is further agreed that this document may be amended or replaced upon the direction for Insurance Company providing insurance protection for C.A.M.P. University.

In the event of any legal claim being filed against C.A.M.P. University by any participant or family member, current or past, C.A.M.P. University, its coordinator, and its board of director will be held harmless, leaving the claimant to pay any and all expenses which may arise for any legal action.

Signed for Participant

____________________________ ____________________________ __________

Parent or Legal Guardian (circle one) C.A.M.P. University Participant Date

C.A.M.P.
UNIVERSITY

C.A.M.P. University Members
Photo Use Consent Form

I, ________________________________, give C.A.M.P. University permission to use
Parent or Legal Guardian

photos, and/or videos of ________________________________ for public
C.A.M.P. University Participant

relation purposes on but not limited to: news articles, brochures, newsletters, social media, and/or presentations showing C.A.M.P. University activities to prospective new members, their families, or to prospective donors.

Signed for Participant

______________________________	______________________________	__________
Parent or Legal Guardian	C.A.M.P. University Participant	Date

Automatic Draft Form

Family Information(required) Please Print in Capital Letters

Student Name : ______________________ Phone #: ______________________

DOB: ______________________ Email: ______________________

Parents or Checking Account Holder (Please write below)

Name: ______________________ Street Address: ______________________

City: ____________ State: ____________ County: ______________________

Authorization Agreement for Automatic Draft

I hereby authorize **Camp University** to initiate automatic withdrawals from my account at the financial institution named below. Monthly Payment of: __$__________

Further, I agree not to hold **Camp University** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Camp University** receives a written notice of cancellation from me or my financial institution.

Please Select One Payment Option Listed Below

A. ( ) I want you to Transfer Payments Monthly from my Bank Account

Account Information

Name of Financial Institution: ______________________

Routing Number : __ __ __ __ __ __ __ __ __ (**9 numbers**)

Account Number:

- Checking
- Savings

Signature

Authorized Signature: **Date:**

B. ( ) I want you to Transfer Payments Monthly from My Credit Card

Account Information

Credit Card Account #:

Expiration Date: ______ / ______ **3 Digit Code** (**on the back of card**)_____

Credit Card Type: **Visa** ___ **MasterCard** ___ **Discover** ___ **Amex** ____

Signature

Authorized Signature: **Date:**

Please keep this receipt for future reference

Physical and Medication Records

The following pages are required medical information for both C.A.M.P. University and Special Olympics. They are required for your loved one's safety whether or not they choose to participate in Special Olympics. We do require them to be updated every three years so that we can make accommodations as needed for your loved one and help them in the unlikely event of an emergency.

A parent or guardian can fill out the first four pages. A doctor must fill out the last two pages. Please be sure that the doctor signs and dates their forms.

The completed forms must be turned in at least eight weeks prior to a Special Olympics event for your loved one to be eligible to participate in that event.

Please fill out the medication list with all current medications only and let us know when a medication has changed so the list can be updated. Include any medications that are taken at home. In the event of an emergency we would need to let paramedics know what medications are taken and basic medical history. **Please keep medical forms updated.**

All information is kept confidential and under lock and key.

Please let us know if you have any questions about these forms.

ATHLETE REGISTRATION FORM

Special Olympics

National Special Olympics Program: Texas ______________ Delegation: ______________

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (dd/mm/yyyy):	☐ Female ☐ Male	
Race/Ethnicity (Optional):		
Language(s) Spoken in Athlete's Home (Optional):		
Street Address:	City:	
State/Province:	Country:	Postal Code:
Phone:	E-mail:	
Sports/Activities:		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐ Yes ☐ No		

PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
☐ Same Contact Info as Athlete		
Street Address:	City:	
State/Province:	Country:	Postal Code:
Phone:	E-mail:	

EMERGENCY CONTACT INFORMATION	
☐ Same as Parent/Guardian	
Name:	
Phone:	Relationship:

PHYSICIAN INFORMATION
Physician Name:
Physician Phone:

ATHLETE RELEASE FORM

Special Olympics

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment. (Not common.)

   ☐ I do not consent to blood transfusions. (Not common.)

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using my contact information for communicating with me about Special Olympics.
     - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

Athlete Name:	**E-mail:**
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES ("Agreement") for SPECIAL OLYMPICS

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,

2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,

4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics *Texas* their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: ____________________________

Participant Signature:______________________________

Date signed: ____________________

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: ______________________

Parent guardian/signature:______________________

Date signed: ___________________

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Athlete First & Last Name:____________________ **Preferred Name:**____________

Athlete Date of Birth (mm/dd/yyyy):________________ ☐ Female ☐ Male ☐ Other Gender Identity

STATE PROGRAM: Texas **E-mail:**________________

ASSOCIATED CONDITIONS - Does the athlete have *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:________________

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:____________
☐ Insect Bites or Stings:____________
☐ Food:____________

ASSISTIVE DEVICES - Does the athlete use *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device
☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures
☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid
☐ Implanted Device ☐ Inhaler ☐ Pacemaker
☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*________________

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

Self-injurious behavior during the past year ☐ No ☐ Yes
Aggressive behavior during the past year ☐ No ☐ Yes
Depression *(diagnosed)* ☐ No ☐ Yes
Anxiety *(diagnosed)* ☐ No ☐ Yes

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes
Has any family member or relative died while exercising? ☐ No ☐ Yes
List all medical conditions that run in the athlete's family:

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last Name:____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS								
Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke/TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heart beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes
Endocarditis	☐ No	☐ Yes	**If female athlete, list date of last menstrual period:**____________					

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*:

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability					
Difficulty controlling bowels or bladder	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Numbness or tingling in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Weakness in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Head Tilt	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Spasticity	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW
(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

Athlete Medical Form – **PHYSICAL EXAM**

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:______________________________ **Date of Birth**______________

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	
Thyroid Enlargement	☐ No	☐ Yes		
Lymph Node Enlargement	☐ No	☐ Yes		
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Rhythm	☐ Regular	☐ Irregular		
Lungs	☐ Clear	☐ Not clear		
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+	☐ 4+
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+	☐ 4+
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	
Cyanosis	☐ No	☐ Yes, describe		
Clubbing	☐ No	☐ Yes, describe		

Bowel Sounds	☐ Yes	☐ No		
Hepatomegaly	☐ No	☐ Yes		
Splenomegaly	☐ No	☐ Yes		
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ ☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left	
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Abnormal Gait	☐ No	☐ Yes, describe below		
Spasticity	☐ No	☐ Yes, describe below		
Tremor	☐ No	☐ Yes, describe below		
Neck & Back Mobility	☐ Full	☐ Not full, describe below		
Upper Extremity Mobility	☐ Full	☐ Not full, describe below		
Lower Extremity Mobility	☐ Full	☐ Not full, describe below		
Upper Extremity Strength	☐ Full	☐ Not full, describe below		
Lower Extremity Strength	☐ Full	☐ Not full, describe below		
Loss of Sensitivity	☐ No	☐ Yes, describe below		

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*TO BE COMPLETED BY EXAMINER ONLY*)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe** → ______________________

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

- ☐ Concerning Cardiac Exam
- ☐ Concerning Neurological Exam
- ☐ Other, please describe:
- ☐ Acute Infection
- ☐ Stage II Hypertension or Greater
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Follow up with a neurologist
- ☐ Follow up with a hearing specialist
- ☐ Follow up with a physical therapist
- ☐ Follow up with a primary care physician
- ☐ Follow up with a dentist or dental hygienist
- ☐ Follow up with a nutritionist
- ☐ Other/Exam Notes:

Signature of Licensed Medical Examiner Exam Date	Name: E-mail: Phone: License #:

Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name:____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:____

Specialty:____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

- ☐ Concerning Cardiac Exam
- ☐ Acute Infection
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Concerning Neurological Exam
- ☐ Stage II Hypertension or Greater
- ☐ Hepatomegaly or Splenomegaly
- ☐ Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: ____

Examiner Phone: ____

License: ____

____

Examiner's Signature **Date**

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

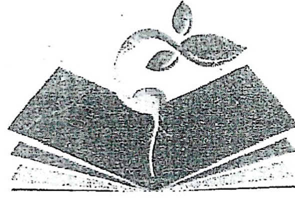
The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

Medication Record

Name of CAMPer: ____

Date Perscribed	Date Stopped	Medication	Dosage	Frequency (i.e. 2x per day)	Time	AM / PM	Reason

For C.A.M.P. University Use Only



4200 N Main, McAllen, TX 78504
PO Box 2294 McAllen, TX 78502
956-800-5292
www.CAMPUniversity.org

Medical Diagnosis Form

Name of Patient:____

Physician:_________________________Physician's Phone:_______________

Physician's Address:________________________City/State/Zip______________

This patient has (check all that apply) ( )Autism ( )Down Syndrome ( )Fragile X Syndrome
( )Cerebral Palsy ( )Fetal Alcohol Syndrome
( )Other syndrome (*please specify*): ______________________________________

Medical Examiner Sign and Date
Signature of Licensed Physician, Physician's Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.

____Date_______________

____
Printed Name

____
License

____
Phone

Page to be completed by medical examiner

PO Box 2294 McAllen, TX 78502
956-800-5292
www.CAMPUniversity.org

August 10, 2021

To be a CAMPer at C.A.M.P. University, please be reminded of our first three requirements. A CAMPer must be able to feed him/herself on their own, to use the restroom on their own, and that there be no history of violence or aggression. We have a zero-tolerance policy for aggression or violence. To ensure that all CAMPers have a pleasant day at C.A.M.P. University, as well as to ensure the safety and well-being of your child, C.A.M.P. University is adopting some new policies. This will be so everyone can have a pleasant experience while at CAMP University.

- If a CAMPer becomes inconsolable at CAMP, or has a difficult day with yelling, wailing, or crying, the CAMPer will need to be picked up by a family member or family friend and be removed from CAMP University for the day.
- If a CAMPer has a restroom accident while attending CAMP University, a family member or family friend will need to come and pick up their CAMPer and take them home. If a CAMPer has more than 3 restroom accidents within a 6-month period, they will need to be removed from CAMP until the problem can be resolved. This does not include menstrual cycles.
- If there has been a change in the routine of a CAMPer that could prove to be upsetting to the CAMPer, C.A.M.P. University requests that we could be made aware of the change so that we can be prepared for helping the CAMPer deal with the changes.

______________________________ Parent's Signature

______________________________ Name of CAMPer

D&S Community Services
8911 N. Capital of Texas Hwy., Building 1, Suite 1300
Austin, Texas 78759
(512) 327-2325 Office; (512) 327-5355 Fax
www.dscommunity.com

STATEMENT FOR RELEASE OF INFORMATION

DATE: ____

FULL NAME OF APPLICANT/EMPLOYEE: ______________________________

PREVIOUSLY USED NAMES (NICKNAMES, MAIDEN NAME, ETC.): ______________________
____

SOCIAL SECURITY NUMBER: ______________________________

DATE OF BIRTH: ______________________________

ADDRESS: ______________________________

YEARS OF RESIDENCY IN TX: ______________________________

DRIVERS LICENSE #: ______________________ ISSUING STATE: ______________

HIRE DATE: ______________________________

I, ______________________________, certify and affirm that to the best of my knowledge and belief ____ ***I have or*** ____ ***I have not (mark with X as applicable)*** had or received a finding of a substantiated case of abuse, neglect, mistreatment, or exploitation against me. In order to verify this affirmation, I further release and authorize D&S Community Services and the Department of Intellectual and Developmental Disabilities to have full and complete access to any and all personnel or investigative records as pertains to any substantiated allegations against me of abuse, neglect, mistreatment, or exploitation.

Signature of Applicant/Employee: ______________________________

Date: ______________________________

Witness: ______________________________

Date: ______________________________

D&S community SERVICES

D&S COMMUNITY SERVICES
AUTHORIZATION AND RELEASE TO OBTAIN INFORMATION

Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., and all applicable federal, state, and local laws, I hereby authorize and permit D&S Residential Services, LP d/b/a D&S Community Services (collectively referred to as "D&S") and its' authorized representatives to obtain a consumer report and/or an investigative consumer report which may include the following:

1. My employment records.
2. Records concerning any driving, criminal history, credit history, civil record, workers' compensation (post-offer only) and drug testing.
3. Verification of my academic and/or professional credentials and information and/or copies of documents from any military service records.

I understand that an 'investigative consumer report' may include information as to my character, general reputation, personal characteristics, and mode of living which may be obtained by interviews with individuals with whom I am acquainted or who may have knowledge concerning any such items of information.

I further agree to release any and all information concerning my background that may be contained in the TBI and FBI databases.

I certify and affirm that to the best of my knowledge and belief, ____***I have or*** ____***I have not (mark with X as applicable)*** had or received a finding of a substantiated case of abuse, neglect, mistreatment, or exploitation against me. In order to verify this affirmation, I further release and authorize D&S and the Texas Department of Aging and Disability Services to have full and complete access to any and all personnel or investigative records as pertains to any substantiated allegations against me of abuse, neglect, mistreatment or exploitation.

I agree that a copy of this authorization has the same effect as an original.

I hereby release and hold harmless D&S, its officers, directors, shareholders, subsidiaries, employees, authorized agents, as well as any person, firm, or entity that discloses matters in accordance with this authorization from liability that might otherwise result from the request for use of and/or disclosure of any or all of the foregoing information.

I understand and acknowledge that under the provisions of the Fair Credit Reporting Act, I may request a copy of any consumer report form the consumer reporting agency that compiled the report, after I have provided proper identification.

I hereby authorize D&S to obtain and prepare an investigative consumer report as set forth above, as part of its investigation of my employment application and continued employment. This authorization shall remain in effect over the course of my employment. Reports may be ordered periodically during the course of my employment.

FULL NAME: ______________________ ______________________ __________

Please Print *Signature* *Date*

WITNESS: ______________________ ______________________ __________

Please Print *Signature* *Date*

D&S COMMUNITY SERVICES

APPLICANT WAIVER

I am applying employment/licensing/education/adoption with the following agency/family.

D&S Community Services

By signing this waiver, I am agreeing to the release of any and all of my criminal history, including any juvenile history that may be in the TBI and FBI databases, to the afforementioned entity, agency.

Signature of Employee/Applicant______________________________

Date: ______________________________

Company Representative: HR Manager

Date: ______________________________

D&S COMMUNITY SERVICES
CONSUMER DISCLOSURE AND AUTHORIZATION FORM

Disclosure Regarding Background Investigation

D&S Residential Services, LP d/b/a D&S Community Services (the "Company") may request, for lawful employment purposes, background information about you from a consumer reporting agency in connection with your employment or application for employment (including independent contractor assignments, as applicable). This background information may be obtained in the form of consumer reports and/or investigative consumer reports (commonly known as 'background reports'). These background reports may be obtained at any time after receipt of your authorization and, if you are hired or engaged by the Company, throughout your employment or contract period.

HireRight, Inc. or another consumer reporting agency, will prepare or assemble the background reports for the Company. HireRight, Inc. is located and can be contacted by mail at 5151 California, Irvine, CA 92617 and HireRight can be contacted by phone at (800) 400-2761. Information about HireRight's privacy practices is available at www.hireright.com/Privacy-Policy.aspx.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: social secuirty number verifications; address history; accident history; worker's compensation claims; bankruptcy filings; educational history verifications (e.g., dates of attendance, degrees obtained; employment history verifications (e.g., dates of employment, salary information, reasons for terminations, etc.); personal and professional reference checks; professional licensing and certification checks; drug/alcohol testing results, and drug/alcohol history in violation of law and/or company policy; and other information bearing on your character, general reputation, personal characteristics, mode of living, and credit standing.

The information may be obtained from private and public record services including, as appropriate, government agencies and courthouses, educational institutions, former employers, personal interviews with sources such as neighbors, friends and associates, and other information sources. If the Company should obtain bearing on your credit worthiness, credit standing, or credit apacity for reasons other than as required by law, then the Company will use such credit information to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being elauated.

You may request more information about the nature and scope of any investigatie consumer reports by contacting the Company. A summary of your rights under the Fair Credit Report Act is also being provided to you.

ADDITIONAL STATE LAW NOTICES

If you are a California, Maine, Massachussetts, New York or Washington State applicant, employee or contractor, please also note:

CALIFORNIA: Pursuant to section 1786.22 of the California Civil Code, you may view the file maintained on you by HireRight during normal business hours. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at HireRight's offices in person, during normal business hours and on reasonable notice, or by certified mail. You may also receive a summary of the file by telephone, upon submitting proper identification and written request. HireRight has trained personnel available to explain your file to you, including any coded information, and will provide a written explanation of any coded information contained in your file. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification. "Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. If you cannot identify yourself with such information, HireRight may require additional information concerning your employment and personal or family history to verify your identity.

MAINE: You have the right, upon request, to be informed of whether an investigative consumer report was requested and, if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries fo rhte consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies, copies of any such reports.

MASSACHUSETTS: If the request was an investigative consumer report, you have the right, upon written request, to a copy of the report.

NEW YORK: You have the right, upon written request, to be informed of whether or not an investigative consumer report was requested. If an investigate consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency. Attached below is additional information about New York law.

WASHINGTON STATE: If the Company requests an investigatie consumer report, you have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate dislosure of the

nature and scope of the investigation requested by the Company. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Authorization of Background Information

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency such as HireRight, Inc. and to release of such background reports to the Company and its designated representatives and agents, for the purpose of assisting the Company in making a determintion as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention, or for other lawful purposes. I understand that if the Company hires me or contacts for my services, my consent will apply, and the Company may obtain background reports throughout my employment or contract period.

I understand that ifnormation contained in my employment or contractor appliation, or otherwise disclosed by me before or during my employment or contact assignment, if any, may be used for the purpose of obtaining and evaluating background reports on me. I also understand that nothing ehrein shall be consrued as an offer of employment or contract for services.

I hereby authorize law enforcement agencies, learning instutitions (including private and publich schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state, and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requesgted by the consumer reporting agency.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate, and complete. I agree that this form in original, faxed, photocopied, or electronic (including electronically signed) form, wil lbe valid for any background reports that may be requested by or on behalf of the Company.

( ) California, Massachusetts, or Oklahoma applicants only: Please check this box if you would like to receive (whenever you have such right under the applicable state law) a copy of your background report if one is obtained on you by the Company.

APPLICANT LAST NAME: ______________________ FIRST: ______________________ MIDDLE: ______________

APPLICANT SIGNATURE: ______________________________________ DATE: ______________________