February 6, 2020

Dear Camper,

It is Camp Time! The Brain Injury Association of Missouri (BIA-MO) Donald Danforth Jr. Wilderness Camp will be held June 21 – 26, 2020. We will be returning to Sunnyhill Adventure Camp in Dittmer, Missouri.

A week of fun, excitement and activity will again include:

- Swimming
- Target Shooting
- Arts and Crafts
- Paddle Boating
- Dinner Dance
- Zip-Lining
- Fishing
- Sports and Games
- Alpine Tower
- Talent Show

As you plan for your adventure at the BIA-MO Donald Danforth Jr. Wilderness Camp, below is important information needed for your registration, preparation and payment.

**Camp Dates**
The Brain Injury Association of Missouri Camp will be held at Sunnyhill Adventure Camp, 6555 Sunlit Way, Dittmer, Missouri 63023 from June 21 – 26, 2020. Campers will check-in at Sunnyhill on Sunday, June 21 between 1:00 pm and 4:00 pm. Departure on Friday, June 26 will be between 10:00 am and 1:00 pm.

**Camp Fee**
All of the activities, accommodations, meals, snacks and more will remain at $390 for survivors of brain injury living in Missouri and $475 for non-Missouri residents. A contracted Camp Fee of $550 is charged to BIA-MO. If you are able to pay closer to this amount, please do so to help scholarships be available for other Campers. The Camp Fee should be sent directly to Sunnyhill Adventure Camp.

If assistance is needed with paying your Camp Fee, please refer to the enclosed *Donation Resources for BIA-MO Camp Fees* sheet, located on page 35 of this packet. A sample letter is enclosed that may be used to help you raise your Camp Fee, or to raise donations toward scholarships for other Campers who may not otherwise be able to attend.

Contact the BIA-MO office at 1-800-444-6443 with questions regarding assistance paying your Camp Fee.

**Registration and Payment**
The enclosed Registration Packet must be submitted to Sunnyhill Adventure Camp with a $100 deposit or scholarship request. The full Registration Packet is enclosed. All **required forms and information must be submitted to Sunnyhill by Friday, May 22, 2020. NO EXCEPTIONS.** Your completed registration, deposit and Camp Fee payment should be sent directly to Sunnyhill Adventure Camp, 6555 Sunlit Way, Dittmer, MO 63023. Include “BIA-MO” and Camper Name in the memo section of the check or credit card form.

(over)
Medications
All medications must be in original, pharmacy-issued packaging with the Camper's name and prescribed dosage. Sunnyhill medical personnel can only distribute medication as prescribed by the physician on the medication packaging.

Begin saving medication bottles now so you will have them available for Camp. You may also check with your Pharmacist about a Camp-prescription with only the quantity and dosage that will be needed for the week of Camp.

DO NOT pack any medications in your luggage. All medications must be given to Sunnyhill staff at check-in or when loading the transportation van.

Walk-Float-Swim
We will again have the Walk-Float-Swim fundraiser at Camp. Information can be found on page 38 of the Registration Packet.

Transportation
Transportation will be available from St. Joseph, Kansas City, Columbia and St. Louis. This service will be provided by a Sunnyhill operated 15-passenger van. The cost for transportation will remain at $25 per person.

The enclosed Van Transportation Request form must be returned with your registration, as space is limited on the transportation vans. The Van Transportation Request form is page 34 of the registration packet.

Campers not riding the bus are responsible for his or her transportation to and from Sunnyhill Adventure Camp. BIA-MO will send your assigned check-in time the week of June 8, 2020. In general, check-in times at Sunnyhill will be staggered on Sunday, June 21 between 1:00 pm and 4:00 pm. Check-out on Friday, June 26 is before 1:00 pm. Driving directions will be provided.

Personal Care Attendant
Sunnyhill Adventure Camp will provide personal care assistance for Campers. If a Camper prefers to bring his or her own Personal Care Attendant, a meal fee of $150 will be applied.

Clarification has been received that Sunnyhill is classified as a Special Needs Camp, not a Special Medical Needs Camp, as defined by the American Camp Association. First-time campers with complex medical needs (such as tracheostomy tubes, colostomy bags, internal catheters and GI tubes) are requested to provide their own Personal Care Attendant (PCA). The PCA will provide all personal and daily assistance for the Camper and will participate in Camp activities. The PCA meal fee of $150 is waived for PCAs of Campers with complex medical need only. If you are unsure of your need for a PCA, please contact Sunnyhill Adventures at 636-274-9044.

We look forward to the Annual BIA-MO Donald Danforth Jr. Wilderness Camp. This great tradition will include a week of fun, adventure and friendships for survivors, while family caregivers enjoy a week of respite.

Sincerely,

Maureen Cunningham
Brain Injury Association of Missouri
Executive Director

**Please keep this letter for your reference**
Thank you for registering to attend Camp at Sunnyhill Adventures this summer!
You must register no later than Friday, May 22, 2020.

Check in and Out Times
(times are strictly adhered to)

Your assigned check-in time will be sent to you the week of June 15, 2020. Check-in times will be Sunday, June 21, 2020 between 1:00pm and 4:00pm. Check-out time is Friday, June 26, 2020 before 1:00pm

Please contact the camp office at 636-274-9044 if you must make prior arrangements outside of the above check-in or check-out times.

Late pick up will result in extra fees charged to Camper at the rate of $1.00 minute if previous arrangements have not been made.

Please Note:
- We will no longer be accepting faxed paperwork. (Faxes are often hard to read)
- If someone not at this address is responsible for completing the paperwork, please contact them immediately so they can complete the packet.
- Please look at each page carefully as some of the information is on the back pages of the packet.
- All medications must be in the ORIGINAL CONTAINERS.
- All forms must be signed where indicated and completed. Camper Health Care Recommendations Form 2, which is outlined in green, must be signed by a health care professional if a physical form is NOT provided.
- Bring the Medication Administration Record pages to Check In, do NOT mail with packet
- It is recommended that you make a copy of your completed packet prior to mailing. This copy will be used as a back-up, in the event the packet is lost in the mail to Sunnyhill.

If you have any questions, please call BIA-MO at 800-444-6443 or Sunnyhill at 636-274-9044.
2020 Return Document Checklist
*Do not return this checklist*

Sunnyhill Adventures requires all documents and payments to be received in our office no later than 30 days prior to attending camp.

Completed packets can be mailed to the camp office:

Sunnyhill Adventures, P.O. Box 246, Dittmer, Missouri, 63023
OR

Completed packets can be emailed to camp:
camp@sunnyhillinc.org

Thirty (30) days prior to attending the events of your choice we require documentation in order to ensure safety, privacy and support. This data will enable us to provide you with a level of care that meets or exceeds the standards of many funding agencies as well as the American Camping Association.

Please utilize the following checklist when returning your paperwork. Timely return and full completion will assist in efficiently processing your program request.

*When a Legal Guardian is applicable, his/her signature is required*

Mail the following completed and signed documents to Sunnyhill Adventures by Friday, May 22, 2020.

☐ Sunnyhill Adventures Registration Form BIA-MO Wilderness Camp – 2 pages (pages 9 & 10)
☐ Van Transportation Request (if applicable)
☐ Emergency Information Form - 1 page (page 11)
☐ Support Information - 2 pages (pages 13 & 14)
☐ Consent for Services - 1 page (page 15) *Requires signature from Camper/Guardian
☐ Receipt of Privacy Practices - 1 page (page 16) *Requires signature from Camper/Guardian*
☐ Publication Release - 1 page (page 17) *Requires signature from Camper/Guardian*
☐ Over the Counter Medications - 1 page (page 18) *Requires signature from Camper/Guardian*
☐ Camper Health History Form 1 – outlined in green – 4 pages (pages 19-22) *Requires signature from Camper/Guardian* (front and back) Must be completed and returned.
☐ Camper Health Care Recommendations Form 2 – outlined in green – 1 page (page 23)

MUST be filled out and signed by a health care provider, OR, you can attach annual physical documentation. The form or the physical must be less than 2 years old.

Bring the following item to CHECK-IN! (Do not mail with the rest of the packet!)
**Please fill out as close to check in as possible to ensure that the medications are correct. If mailed 30 days prior with the packet, there is a chance meds would change before camp!**

☐ Medication Administration Record - 4 pages (page 27-33)
☐ Walk-Float-Swim Form – 1 page (page 42)

(OVER)
Sunnyhill Adventures
Camp Packing Checklist
(Keep this page)

Please be sure to write the camper's name on every item that is sent, including luggage, bedding, and clothing. Sunnyhill Adventures and the Brain Injury Association of Missouri are not responsible for lost items.

☐ 1 waterproof poncho or jacket
☐ 1 jacket
☐ 7 full changes of clothing suitable for outdoor activities (at least 2 pairs of long pants)
☐ 1 pair of comfortable walking shoes
☐ 1 or 2 sleeping outfits
☐ 2 towels
☐ Personal hygiene items
☐ 1 hat
☐ 1 swimsuit
☐ Water shoes to be worn in pool or water activities
☐ 1 flashlight
☐ 1 32oz waterproof drinking bottle
☐ 1 set of bedding (1 pillow, 1 fitted sheet and blanket or sleeping bag)
☐ 1 recent photo for identification
☐ Any necessary personal equipment (glucometer, etc.)
   • Please label personal equipment and all components with the camper's name
☐ All medication — must be in original container with current, legible, unaltered dosing instructions.

Optional Items: camera, games, spending money for the camp store. The camp store will only be open Friday, June 26 between 9:00am and 11:00am.

DO NOT BRING: radio, tv, video games, food and snacks, expensive items, clothing of value, weapons, alcoholic beverages, drugs, pets, and sporting equipment. Sunnyhill and the Brain Injury Association of Missouri are not responsible for lost or stolen items.

Please call Sunnyhill or BIA-MO if you have any questions or concerns.

Thank you!
Sunnyhill Adventures
NOTICE OF PRIVACY PRACTICES
(Keep these pages, DO NOT return to Sunnyhill Adventures, pages 3-6)
Effective: April 14, 2003
Revised: September 20, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a doctor, hospital, pharmacist or any other person that provides you health care services, a record of your visit is made. Typically this record contains information about you, such as reasons why you are seeking medical care, a plan for future care and billing information. Sunnyhill, Inc. ("Sunnyhill") understands that this information, often referred to as your "medical information" or "health information," is personal.

Sunnyhill is required by law to maintain the privacy of your health information, and to provide you with a notice of our legal duties and privacy practices with respect to such information. This Notice of Privacy Practices ("Notice") describes your legal rights, advises you of our privacy practices, and lets you know how Sunnyhill is permitted to use and disclose your health information. We will provide you with a copy of the current Notice the first time you receive services from Sunnyhill on or after April 14, 2003. We will also post a copy of the current Notice in our facility.

Sunnyhill is required to abide by the terms of the Notice currently in effect. In most situations we may use this information as described in this Notice without your permission (known as an "authorization"), but there are some situations where we may use it only after we obtain your written authorization, if law requires that we do so.

Sunnyhill reserves the right to change our privacy practices and revise our Notice. Such changes will be effective immediately and will apply to all health information that we maintain. The Notice will contain the effective date on the first page. If we have already provided you with a copy of the Notice, and later our privacy practices change and we revise our Notice, you may obtain a copy of the revised Notice by (1) asking for a copy of the current Notice to take home with you the next time you visit or receive health care services from Sunnyhill, (2) downloading the current Notice from our website at www.sunnyhillinc.org, or (3) contacting us at (314) 845-3900, and/or submitting your request in writing to: Sunnyhill, Inc., 14 Soccer Park Rd., Fenton, MO 63026 Attention: Privacy Officer.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
The following categories describe different ways that we may use and disclose your health information, and include some examples to explain such uses and disclosures. Not every use or disclosure in a category will be listed.

Some uses and disclosures of health information may be subject to additional restrictions under federal and state laws and regulations, such as those that apply to substance abuse treatment, HIV/AIDS testing and treatment, and mental health treatment. For example, if you are receiving alcohol or drug abuse services, information that would identify you as a person seeking help for a substance abuse problem is protected under a separate set of federal regulations known as "Confidentiality of Alcohol and Drug Abuse Patient Records," 42 C.F.R. Part 2. Under certain circumstances these regulations will provide your health information with additional privacy protections beyond what is described in this Notice.

For Treatment. We may use and disclose your health information to provide, coordinate and manage the services, supports, and health care you receive from us and other providers. We may disclose your health information to doctors, nurses, qualified developmental disabilities professionals (QDDPs), psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in supporting you or providing care. We may share your health information with other health care providers when we consult with them about your care. For example, our staff may discuss your health information to develop and carry out your individualized service plan, and to coordinate needed services, such as medical tests, transportation, physical therapy, etc. In some instances, our staff may need to disclose your health information to entities outside of our organization (for example, to another provider or a state/local agency) to obtain new services for you.

For Payment. We may use and disclose your health information so we can be paid for the services we provide to you. This can include billing a third party, such as Medicaid or other state agency (for example, the Department of Mental Health) or your insurance company. For example, we may need to provide the Department of Mental Health with information about the services we provide to you so we will be reimbursed for those services. We also may need to provide the state Medicaid program with information to ensure you are eligible for services you are receiving. We may also provide your health information to another health care provider or entity for their payment activities (such as the physician that provides you treatment).

For Health Care Operations. We may use and disclose your health information as necessary to operate Sunnyhill, Inc. and to maintain the quality of services that we provide to our consumers. For example, we may use your health information to review the services we provide and to improve the performance of our employees supporting you. We may disclose your health information to train our staff, students and volunteers. We also may use health information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our continuous quality improvement. There are also some circumstances that we are permitted to disclose your health information to another health care provider (such as a physician to which we refer you) for his or her own health care operations.

Business Associates. We may disclose your health information to certain individuals and companies that we contract with (our "business associates") so that they can perform the job we have asked them to do. For example, we may contract with a billing company to assist us with billing insurance companies and third party
payers so that we can be paid for the services that we provide to you. To protect your health information, however, we require our business associates to appropriately safeguard your health information and to meet the same confidentiality standards that we are required to meet.

Appointment Reminders, Treatment and Service Alternatives and Health Related Benefits and Services. We may use and disclose your health information to contact you to remind you of a scheduled appointment or to contact you about treatment and service alternatives or health-related benefits and services that may be of interest to you.

Marketing Communication. We may use and disclose your health information to tell you about a product or service to encourage you to purchase the product or service. For example, we may send you a newsletter or other mailings about certain educational programs. We will not, however, sell or distribute your health information to third parties who do not have a relationship with us unless we have obtained an authorization from you. For instance, we would not release information or patient lists to pharmaceutical companies for those companies’ drug promotions unless we have your authorization to do so.

Fundraising. We may use and disclose your health information so that we (or one of our business associates) can contact you to raise funds for the benefit of Sunnyhill. We will only release demographic information, such as your name and address, and the dates you received treatment or services from us. If you do not want Sunnyhill to contact you for fundraising purposes, please notify: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd., Fenton, MO 63026.

Disclosures to Family and Others. We may disclose your health information to one of your family members, relatives, close personal friends, or to any other person identified by you, but we will only disclose information which we feel is relevant to that person’s involvement in your care or the payment for your care. If you are feeling well enough to make decisions about your care, we will follow your directions as to who is sufficiently involved in your care to receive information. If you are not present or cannot make these decisions, we will make a decision based on our experience as to whether it is in your best interest for a family member or friend to receive information about you and how much information they should receive. If there is a family member, other relative, or close personal friend that you do not want us to disclose your health information to, please notify the staff that assists you.

We may disclose your health information to an entity assisting in disaster relief efforts (for example, the American Red Cross) so your family can be notified about your condition, status and location in an emergency.

Required by Law. We will disclose your health information when we are required to do so by federal, state or local law. For instance, we are obligated to report suspected child abuse to the proper authorities.

Public Health Activities. We may disclose your health information for public health activities and purposes. For example, we may report health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, neglect, reporting reactions to medications or problems with health care products, or notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations. For example, we must make our books, records, and other information available to the government agencies in charge of overseeing Medicare and Medicaid so that we can show these agencies that we are complying with Medicare and Medicaid provider requirements.

Judicial and Administrative Proceedings. We may disclose your health information if we are ordered to do so by a court or administrative tribunal. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Disclosures for Law Enforcement Purposes. We may release your health information to a properly identified law enforcement official in the following situations:
• As required by law.
• In response to a court order, subpoena, warrant, summons or similar process.
• To assist law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
• In certain limited circumstances, if you are, or we suspect you are, the victim of a crime and we are unable to obtain your agreement.
• If we believe that a death may be the result of criminal conduct.
• If we believe that the information constitutes evidence of criminal conduct occurring at our facility.
• In emergency circumstances to report a crime, if it appears necessary to disclose the information related to the commission and nature of a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Uses and Disclosures Regarding Decedents. We may release information about a deceased person to a coroner or medical examiner to identify the person, determine the cause of death or perform other duties recognized by law. We may also release a deceased person’s health information to a funeral director as necessary to carry out their duties.
Organ, Eye or Tissue Donation. If you are an organ donor, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue.

Research. Under certain circumstances, we may use or disclose your health information for research. Before we disclose health information for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy of your health information. We may, however, disclose your health information to a person who is preparing to conduct research to permit them to prepare for the project, but no health information will leave Sunnyhill during that person’s review of the information. Enrollment in most of these research projects can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate in the study by signing a consent form. Other studies may be performed using your health information without requiring your consent. These studies will not affect your treatment or welfare, and your health information will continue to be protected. For example, a research study may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

To Avert Serious Threat to Health or Safety. We may use or disclose your health information if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We also may release your health information if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

For Specified Government Functions. In certain circumstances, federal regulations authorize us to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations, inmates and law enforcement custody. For example, if you are a member of the Armed Forces, we may use and disclose your health information to appropriate military command authorities for activities they deem necessary to carry out their military mission.

Workers Compensation. We may disclose your health information as authorized by, and to the extent necessary to comply with, laws relating to workers’ compensation or similar programs that provide benefits for work-related injuries or illness.

Uses and Disclosure Requiring your Written Permission. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your specific written permission (sometimes known as an “authorization”). If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
Although your health record is the physical property of Sunnyhill, Inc., the information contained in the record belongs to you. The following describes your rights with respect to your health information that we maintain.

Right to Request Restrictions. You have the right to request that we restrict the uses or disclosures of your health information that we may make to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to a family member, other relative, a close personal friend or any other person identified by you. For example, you could ask that we not disclose your health information to your brother or sister who comes in to talk to us. You may request a restriction at any time by submitting your request in writing to: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026, and include: (a) what information you want to limit, (b) whether you want to limit use or disclosure or both, and (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. However, if we do not agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, you can let us know later that you do not want us to continue to comply with your request.

Right to Receive Confidential Communications. You have the right to request that we communicate your health information to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication. If you want to request confidential communication, you must do so in writing to: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026. Your request must state how or where you can be contacted.

We will use our best efforts to accommodate all reasonable requests. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

Right to Inspect and Copy. With a few very limited exceptions, you have the right to inspect and obtain a copy of your health information that we maintain. To inspect or copy your health information, you must submit your request in writing to: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026. Your request should state specifically what health information you want to inspect or copy. If you request a copy, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend. You have the right to request an amendment (correction) to your health record if you feel that the information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. To request an amendment, you must submit your request in writing to: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026. In addition, you must provide a reason that supports your request. Although you are permitted to request that we amend your health information, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information we keep;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to a “accounting of disclosures.” An accounting of disclosures is a list of the disclosures of your health information that we have made, with some exceptions. To request this list, you must submit your request in writing to: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026. Your request must state a time period which may not be longer than six years prior to the date of the request. The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to a Breach Notification. You have the right to be notified of any suspected or confirmed breach of your health information by Sunnyhill. You will be notified of breaches by first-class mail, or alternatively, by e-mail if you have previously agreed to receive such notices electronically. If we no longer have up-to-date contact information for you, we may post notice of breaches on our website, in local media, or attempt to contact you by telephone. You will be notified of such breaches no later than 60 days following the discovery of the breach. Your notification will include, to the extent possible, a description of the breach; a description of the types of information that were involved in the breach; the steps you could take to protect yourself from potential harm; a brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches; and our contact information.

Right to Copy of this Notice. You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain a paper copy even if you have previously agreed to receive the notice electronically. You may request a copy of our current Notice of Privacy Practices at any time by (1) asking for a copy of the Notice to take home with you the next time you visit or receive health care services at our facility, (2) contacting (314) 845-3900, or (3) submitting your request in writing to Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026.

You may also obtain a copy of our Notice of Privacy Practices at our web site, www.sunnyhillinc.org.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services.

- To file a written complaint with us, contact Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd, Fenton, MO 63026.
- To file a complaint with the Secretary of the U.S. Department of Health and Human Services—Office for Civil Rights, 601 East 12th Street—Room 248, Kansas City, MO 64106, or call (816) 426-7278.

Questions and Information. If you have any questions or want more information concerning this Notice of Privacy Practices, please contact: Privacy Officer, Sunnyhill, Inc., 14 Soccer Park Rd., Fenton, MO 63026 or call (314) 845-3900.
Sunnyhill Adventures Registration – BIA-MO Wilderness Camp
June 21-26, 2020

Participant’s Name: ____________________________________________
Participant Address: ____________________________________________
Participant Email: ____________________________________________
Phone: ___________________________ Male ☐ Female ☐ Age: _____ circle one: Adult (over 18) or Youth
Race/Ethnicity (circle one): African American Asian Hispanic Native American White Other
Did you attend BIA-MO camp last year? Yes ☐ No ☐
What year was the participant’s brain injury diagnosed? ____________________________
How did the participant’s brain injury occur? ____________________________

Staff to Camper Ratio

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<tr>
<th>Mark One</th>
<th>Ratio</th>
<th>Description</th>
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<tr>
<td>1:1</td>
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<td>Choose this option if camper requires hands on assistance with toileting, is a flight risk, has physical documentation of fall risk, or has behavioral needs that are addressed through a behavior support plan.</td>
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<tr>
<td>1:3</td>
<td></td>
<td>Camper follows directions and needs minor assistance with toileting, walking, moving wheelchair, eating or other daily living skills.</td>
</tr>
<tr>
<td>1:5</td>
<td></td>
<td>Choose this option if camper responds to verbal prompts for assistance and does not require extensive assistance to complete Adult Daily Living Skills.</td>
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For clarification, please contact BIA-MO at 800-444-6443 or Sunnyhill Adventures at 636-274-9044.

Is the participant a recipient of DMH/Regional Center Services? Yes ☐ No ☐
DMH/Regional Center’s Case Manager’s Name: ____________________________
Case Manager’s Phone: ____________ Case Manager’s Email: ________
Does the participant utilize any adaptive equipment or require special assistance (wheelchair, talking board, etc.)? Yes ☐ No ☐ If yes, please explain (Please attach additional page if needed): ____________________________

Primary Care Physician: ____________________________ Phone: ____________

At Camp Requests:
Top five activities in which you would like to participate:

☐ Bonfire ☐ Arts & Crafts ☐ Rock Climbing Wall ☐ Paddle Boat ☐ Dinner Dance
☐ Zip line ☐ Swimming ☐ Alpine Tower ☐ Talent Show ☐ Karaoke ☐ Fishing
What three songs would you like to hear during the Dinner Dance? (If it has clean lyrics and can be found or played by the performer.)

<table>
<thead>
<tr>
<th>Title</th>
<th>Artist, if known</th>
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Photo/Video Release: BIA-MO and Sunnyhill Adventures have my permission to photograph and/or videotape Camper/Myself during the duration of Camp. I understand photographs and videotapes may be used for promotional and outreach purposes.

Legal/Guardian/Camper Signature ___________________________ Date ___/___/___
Print Name ___________________________ Relation to Camper __________________

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<thead>
<tr>
<th>Additional Contact</th>
<th>Service Provider (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Email Address:</td>
<td>Email Address:</td>
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<tr>
<td>Phone:</td>
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</tbody>
</table>

Mail Camp Information to: ☐ Participant ☐ Additional Contact ☐ Service Provider

Method of Payment: (choose all that apply)
☐ Pay now with card Amount $_________ Name on Card:_________________________
  Card Number: __________________ Type: ___________ Exp: ___________ CVC: ______
  Billing Street Address: ___________________________ Billing Zip Code: ________
☐ Check Number: _______ Amount $_________
☐ Recreation Council Amount $_________ ☐ St. Louis County ☐ St. Louis City ☐ St. Charles County
☐ Department of Mental Health Amount $_________
  Contact Person: ___________________________ Phone: _______________________
☐ SB40 Board (County) Name of County: _______________________
☐ Friends and Family Assisting (see Resources for Camp Fees, pg. 34) Amount $_________
☐ Other: ___________________________________ Amount $_________

☐ Scholarship Requested from BIA-MO: ☐ $_______ Partial Scholarship ☐ $390 Full Scholarship
(Subscription of approval will be sent within 10 days of receipt of this request and registration form.)

Deposit of $100 must be included or form will not be accepted.
Mail completed form and deposit to:
Sunnyhill Adventures P.O. Box 246, Dittmer, MO 63023

Complete Registration Forms MUST be received at Sunnyhill by Friday, May 22, 2019. No exceptions.

Important Notes:
- Your deposit is applied to total camp fees.
- No registration will be accepted unless accompanied by deposit or guarantee letter from funding source.
- Balance of program fees are due 30 days prior to program start date.
- No refunds will be issued unless cancellation is made 30 days prior to program start.

For more information or additional copies of this packet, please visit www.biamo.org
Sunnyhill Adventures
2020 Emergency Information Form
Please print clearly in all areas.

Camper Information: *Does Camper have a Legal Guardian? Yes___ No___
Name: ____________________________________________________________________________
Last                      First                      M.I.                      __/__/____
Date of birth
Home Address: ________________________________________________________________
Street                      City                      State                      Zip
Phone Number: (_____) ____________________________ (_____) ____________________________
Main Phone                      Alternate Phone
Age at camp: _____ Gender (circle one): Male   Female

Parent/Legal Guardian Information:
Name: ____________________________________________________________________________
Last                      First                      Relationship
Home address: ________________________________________________________________
Street                      City                      State                      Zip
Phone Number: (_____) ____________________________ (_____) ____________________________
Main Phone                      Alternate Phone

Emergency Contact Information:
In the order of importance, please list the person you want contacted in case of an emergency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Cell Phone Number</th>
<th>Home Phone Number</th>
<th>Work Phone Number</th>
</tr>
</thead>
<tbody>
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</table>

Picking up Camper:
Please list all people who are permitted to pick up this Camper.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Cell Phone Number</th>
<th>Home Phone Number</th>
<th>Work Phone Number</th>
</tr>
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</table>

Case Management Information:
Is the Camper a recipient of case management services? (Circle One) Yes   No
If yes, please list the Case Manager’s name: ____________________________ Phone: ____________________________
Sunnyhill Adventures
2020 Support Information
Page 1 of 2

Sunnyhill Adventures strives to include all persons of all ability levels within our programs. Some of our Campers require support; many do not. We require all Campers to fill out the same intake information, so we are able to provide the best experience possible for all. It is likely that many areas may not pertain to you; however, we ask you to complete this form as fully as possible. This information will be used by Sunnyhill Adventure staff as well as office personnel to assist Campers in receiving the quality experience they seek. Thank you for your cooperation.

1. Campers personal goals:
   Please list what the camper would like to achieve while at camp:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Estimate the camper’s ability for items 2 through 7.

2. Swimming: (Circle one)  
   Advanced  Intermediate  Beginner  Non-swimmer
   Fear of water? (Circle one)  
   Yes  No
   Indicate specific assistance needed: __________________________________________________________

3. Dressing: (Circle one)  
   Independent  Needs assistance
   Indicate specific assistance needed: __________________________________________________________

4. Personal hygiene: (Circle one)  
   Independent  Needs assistance
   Indicate specific assistance needed: __________________________________________________________

5. Eating: (Circle one)  
   Independent  Needs assistance
   Indicate specific assistance needed: __________________________________________________________

6. Socializing: (Circle one)  
   Independent  Needs assistance
   Indicate specific assistance needed: __________________________________________________________

(OVER)
2020 Support Information

7. Walking: (Circle one) Independent Needs assistance
   *If Camper is likely to become fatigued while walking long distances, please send a wheelchair, walker or cane with the Camper.
   Indicate specific assistance needed:

8. Camper’s preferred activities:

9. Does the Camper have any non-typical sleep habits? (Circle one) Yes No
   If yes, explain:

10. Is there a history of alcohol/drug abuse? (Circle one) Yes No
    If yes, explain:

11. Does the Camper require rest periods? (Circle one) Yes No
    If yes, explain:

12. Is the Camper a smoker? (Circle one) Yes No

13. Is the Camper a diabetic and require insulin injections? Yes No

14. Is the Camper currently engaged in a Behavioral Support Plan? (Circle one) Yes No
    If yes, please have the behavior specialist and/or the case manager send a copy of the information relating to the behaviors. We will also need a written statement describing the camp staff's specific role as it relates to the implementation of the behavior management plan.

Is there any other pertinent information we should know? (Attach additional pages if necessary)
Sunnyhill Adventures
2020 Consent for Services

In consideration of admission of ________________________________(Camper’s Full Name), for the various programs conducted by Sunnyhill Adventures, a program of Sunnyhill Inc., I/we give the unqualified right and permission to:

1. Administer medications as provided by me, the parent, Legal Guardian, or staff according to a physician’s prescription and/or administer approved non-prescription drugs if required.

2. Participate in camp activities on and off site including but not limited to: swimming, canoeing, boating, indoor wall climbing, outdoor wall climbing, tower climbing, archery, zip-lining, caving, programs and activities off camp and in the community, riding in vehicles, and all camp activities, etc.

3. In the event that I cannot be reached in an emergency, I hereby give permission to transport the above named participant and secure treatment at a health care facility at my expense.

4. I hereby indemnify Sunnyhill Inc., its’ agents and employees, and agree to hold it and them harmless from any and all liability arising out of any injury, or accident that might happen to the participant, and from any damage the participant might cause to any person(s) or property while in the care of Sunnyhill Inc., its’ agents and employees. I further understand that the participant can be excluded at any time during the program by the director if it is judged that the participant has hampered the safety, welfare, or enjoyment of self or other in the program.

I have read the foregoing, which I understand to be Consent for Services, release and indemnification, and I understand this fully.

In witness whereof, I have executed this consent and indemnification.

Camper Signature:

Date: __________________________

Legal Guardian Signature:

Date: __________________________

(OVER)
Sunnyhill Adventures
2020 Receipt of Privacy Practice Signature Letter
(Notice of Privacy Practices is pages 5-8 of the packet)

Dear Camper or Legal Guardian;

We are required under the Health Insurance Portability and Accountability Act (HIPPA) privacy regulation to put safeguards in place to protect the privacy of information, including providing you with a Notice of Privacy Practice. We want to assure you that we not only meet these requirements but also take steps to create the secure environment for on-going protection of information. The purpose of this letter is to inform you about the requirements and practices we have implemented.

We have and will continue to review and update our practices in relation to HIPPA privacy regulation by:

- On-going training for our employees.
- Establishing safeguards for the protection of individual health identifiable information.
- Ensuring access to information only as permitted by law.

If you have any questions, please feel free to call us at 636-274-9044.

Sincerely,
Sunnyhill Adventures

I have received and reviewed a copy of Sunnyhill Adventures Notice of Privacy Practices.
(Pages 3-6 of packet)

Camper Full Printed Name

__________________________

Date: ______________________

Camper Signature

__________________________

Date: ______________________

Legal Guardian Signature

__________________________

Date: ______________________
Sunnyhill Adventures
Publication Release Form
Expires on January 1, 2021

Sunnyhill Adventures will at times create video or photographic material of Campers during programs for the purpose of marketing.

For Campers over 18 you/your Legal Guardian’s signature on this document gives us permission to use these photographs or videos until January 1, 2021.

For Campers under 18, your parent or Legal Guardian’s signature on this document gives us permission to use these photographs or video items until January 1, 2021.

☐ I give permission to use photographs or videos of _________________________________.

Camper Full Printed Name

Date: ______________________

Camper Signature

Date: ______________________

Legal Guardian Signature

OR

☐ I DO NOT give permission to use photographs or videos of _________________________________.

Camper Full Printed Name

Date: ______________________

Camper Signature

Date: ______________________

Legal Guardian Signature
Sunnyhill Adventures
Over the Counter Medications

These medications will typically be available in the Nurse’s Station.

☐ I give Sunnyhill Adventures permission to administer the following over the counter medications as needed:

- [ ] Tylenol
- [ ] Pepto Bismol
- [ ] Ibuprofen
- [ ] Kapectate
- [ ] Cough Syrup
- [ ] Throat Lozenges
- [ ] Other _______________________

Camper Signature
Date: _______________________

Legal Guardian Signature
Date: _______________________

OR

☐ I **DO NOT** give Sunnyhill Adventures permission to administer the above over the counter medications as needed.

Camper Signature
Date: _______________________

Legal Guardian Signature
Date: _______________________

Other notes Sunnyhill Adventures Staff should be aware of:
(diet restrictions, etc.)

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

BIA-MO Sunnyhill Adventures Camp Packet 2020: Page 18
CAMPER HEALTH HISTORY FORM 1

Sunnyhill Adventures
P.O. Box 246
Dittmer, MO 63023

Camper Name:

Dates will attend camp: from __________________ to __________________

Month/Day/Year

Month/Day/Year

Male □ Female □

Birth Date:

Month/Day/Year

Age on arrival at camp: __________________

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.

2) Send the original, signed FORM 1 to camp by the requested date.

3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child’s health-care provider for review and completion.

4) After it has been completed and signed by your child’s health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address:

Street Address

City

State

Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: __________________________

Relationship: ____________________

to Camper: ____________________

Preferred Phones: ( ) ( )

Email: _________________________

Home Address:

Street Address

City

State

Zip Code

If different from above:

Second parent/guardian or other emergency contact:

Name: __________________________

Relationship: ____________________

to Camper: ____________________

Preferred Phones: ( ) ( )

Email: _________________________

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: __________________________

Relationship: ____________________

to Camper: ____________________

Preferred Phones: ( ) ( )

Allergies: □ No known allergies. □ This camper is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) □ Other

(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition:

☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant.

☐ Other, please explain in space.

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.

(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company __________________________ Policy Number __________________________

Subscriber __________________________ Insurance Company Phone Number ( )

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. This person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

Signature of Custodial Parent/Guardian: __________________________ Relationship to Camper: __________________________ Date: __________________________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.
CAMPER HEALTH HISTORY FORM 1
Developed and reviewed by American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1 Month/Year</th>
<th>Dose 2 Month/Year</th>
<th>Dose 3 Month/Year</th>
<th>Dose 4 Month/Year</th>
<th>Dose 5 Most Recent Dose Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria, tetanus, pertussis</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>(DTaP) or (TTaP)</td>
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<tr>
<td>Tetanus booster* (dT)</td>
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<td>(dTaP) or (TTaP)</td>
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<td>Mumps, measles, rubella</td>
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<tr>
<td>(MMR)</td>
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<td>Polio (IPV)</td>
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<tr>
<td>Haemophilus influenza type B</td>
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<td>(Hib)</td>
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<tr>
<td>Pneumococcal (PCV)</td>
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<tr>
<td>Hepatitis B</td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td></td>
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<tr>
<td>Varicella (chicken pox)</td>
<td>☐ Had chicken pox</td>
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<tr>
<td>Date:</td>
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<td>Meningococcal meningitis</td>
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<td>(MCV4)</td>
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Tuberculosis (TB) test
Date: ☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: ___________________________ Date: ___________ Relationship: ___________ to Camper: ___________________________

Medication:
☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp.

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Date started</th>
<th>Reason for taking it</th>
<th>When it is given</th>
<th>Amount or dose given</th>
<th>How it is given</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Breakfast</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Lunch</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>☐ Dinner</td>
<td></td>
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<td>☐ Bedtime</td>
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<td></td>
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<td>☐ Other time:</td>
<td></td>
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</tr>
</tbody>
</table>

Do NOT fill out, please use included MAR instead

|                    |              |                       | ☐ Breakfast        |                      |                 |
|                    |              |                       | ☐ Lunch            |                      |                 |
|                    |              |                       | ☐ Dinner           |                      |                 |
|                    |              |                       | ☐ Bedtime          |                      |                 |
|                    |              |                       | ☐ Other time:       |                      |                 |

Do NOT fill out, please use included MAR instead

*Medication* is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Cross out those the camper should not be given.

- Acetaminophen (Tylenol)
- Phenylephrine decongestant (Sudafed PE)
- Antihistamine/allergy medicine
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Sore throat spray
- Lice shampoo or cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Ibuprofen (Advil, Motrin)
- Pseudoephedrine decongestant (Sudafed)
- Quinolone cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Generic cough drops
- Antibiotic cream
- Aloe
- Bismuth subsalicylate for diarrhea (Kapectate, Pepto-Bismol)

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CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses.

Camper Name: ___________________________
First Name:
Middle Name:
Last Name:

Birth Date: __________/_______/_______
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

1. Ever been hospitalized? ................. [ ] Yes [ ] No
2. Ever had surgery? ......................... [ ] Yes [ ] No
3. Have recurrent/chronic illnesses? ....... [ ] Yes [ ] No
4. Had a recent infectious disease? ........ [ ] Yes [ ] No
5. Had a recent injury? ....................... [ ] Yes [ ] No
6. Had asthma/ wheezing/ shortness of breath? [ ] Yes [ ] No
7. Have diabetes? ............................. [ ] Yes [ ] No
8. Had seizures? .............................. [ ] Yes [ ] No
9. Had headaches? ........................... [ ] Yes [ ] No
10. Wear glasses, contacts, or protective eyewear? [ ] Yes [ ] No
11. Had fainting or dizziness? ................ [ ] Yes [ ] No
12. Passed out/had chest pain during exercise? [ ] Yes [ ] No
13. Had mononucleosis ("mono") during the past 12 months? [ ] Yes [ ] No
14. If female, have problems with periods/ menstruation? [ ] Yes [ ] No
15. Have problems with falling asleep/sleepwalking? [ ] Yes [ ] No
16. Ever had back/joint problems? ........... [ ] Yes [ ] No
17. Have a history of bedwetting? ............ [ ] Yes [ ] No
18. Have problems with diarrhea/constipation? [ ] Yes [ ] No
19. Have any skin problems? ................. [ ] Yes [ ] No
20. Traveled outside the country in the past 9 months? [ ] Yes [ ] No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? [ ] Yes [ ] No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? [ ] Yes [ ] No
3. During the past 12 months, seen a professional to address mental/ emotional health concerns? [ ] Yes [ ] No
4. Had a significant life event that continues to affect the camper’s life? [ ] Yes [ ] No

(Examples: history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper’s primary doctor(s): ________________________________ Phone: (_______)
Name of dentist(s): ______________________________________________ Phone: (_______)
Name of orthodontist(s): _________________________________________ Phone: (_______)

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Page 3/4
Rev.1/2014 LEE/EAW

Sunnyhill Adventures Camp Packet 2020: Page 21
Individual Health Record (For Camp Use Only)

Initial Screening  Date/Time: ______  Initials: ______

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival? ... No ☐ Yes as noted below
B. History of exposure to communicable disease? ... No ☐ Yes as noted below
C. Additions or corrections to information on this health history? ... No ☐ Yes as noted below
D. Medication given to health-care staff? ... No ☐ Yes as noted below
E. Any signs/symptoms of head lice? ... No ☐ Yes as noted below

Provider notes: (date/time/initial all entries)

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.
☐ Left camp this day with the following problem/concern:

________________________________________________________

This person was told about the problem and instructed about follow-up as noted above:

Date/Time: ______  Initials: ______

________________________________________________________

Camper Name:

First  Middle  Last  

Birth Date: ______/______/______

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To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review. Dates will attend camp: from ________________ to ________________.

Camper Name: __________________________

First Middle Last

Male [ ] Female [ ] Birth Date ________________ Age on arrival at camp ________________

Camper home address: __________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Custodial parent(s)/guardian(s) phone: (________) (________) (________)

(Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.)

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: [ ] Yes [ ] No (If "No," date of last physical: ________________)

ACA accreditation standards specify physical exam within the last 24 months.

Weight: ______ lbs Height: ______ ft ______ in Blood Pressure: ______/______

Allergies: [ ] No Known Allergies

[ ] To foods (list): __________________________

[ ] To medications (list): __________________________

[ ] To the environment (insect stings, hay fever, etc.—list): __________________________

[ ] Other allergies (list): __________________________

Describe previous reactions: __________________________

Diet, Nutrition: [ ] Eats a regular diet [ ] Has a medically prescribed meal plan or dietary restrictions (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below): [ ] None.

Medication: [ ] No daily medications. [ ] Will take the following prescribed medication(s) while at camp: (name, dose, frequency—describe below)

Other treatments/therapies to be continued at camp: (describe below): [ ] None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? [ ] No [ ] Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): __________________________

Signature: __________________________

Office Address: __________________________ Street: __________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Telephone: (________) Date: ________________
Medication Administration Record Instructions

PLEASE READ CAREFULLY!

In an effort to speed up check in this year, we have updated the medication form. Instead of us filing out the medication administration sheet when you arrive at camp, we are including the form that we will use for you to fill out ahead of time. At check in, a staff member will go through each medication and verify that it matches the pharmacy label. **In order to eliminate us re-writing all of the medications and extending check in time, it is very important that the form is filled out completely and correctly. We have provided an example to guide you.**

MEDICATION WILL ONLY BE ADMINISTERED AS PRESCRIBED BY THE PHARMACY LABEL, NO EXCEPTIONS.

Please follow these instructions in order for us to ensure each Camper will receive correct medication as prescribed by the physician.

1. Send medication in its **ORIGINAL bottle** with correct dosing instruction labeled by the pharmacy.
2. Send one extra dose of medication.
3. Send all medication bottles in one (1) large Ziploc type bag that is clearly labeled with the Camper’s full name.

Again, we will only administer the medications as they are written on the pharmacy label!

EXAMPLE:

<table>
<thead>
<tr>
<th>Verified at Check In</th>
<th>To Be Filled out by Parent/Guardian/Support Staff</th>
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</thead>
<tbody>
<tr>
<td>Medication Name</td>
<td>Dose</td>
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<tr>
<td>Staff</td>
<td>Alprazolam</td>
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<td>Drop off Person</td>
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Please **DO NOT** fill out the columns on the right side of the form. This is how staff document that they have given the medications to the camper.
# Sunnyhill Adventures
## Camp Medication Administration Record

<table>
<thead>
<tr>
<th>Verified at Check In</th>
<th>To Be Filled out by Parent/Guardian/Support Staff</th>
<th>(Camp Use Only) Staff Initials for Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name</td>
<td>Dose</td>
<td># of Tabs/Caps &amp; Frequency</td>
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<td>Staff</td>
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Continue medications on next pages if needed ➡️

Notes:

Allergies:

Administered by(Camp Use Only):  

BIA-MO Sunnyhill Adventures Camp Packet 2020: Page 27
# Sunnyhill Adventures
## Camp Medication Administration Record

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<tr>
<th>Verified at Check In</th>
<th>To Be Filled out by Parent/Guardian/Support Staff</th>
<th>Staff Initials for Administration (Camp Use Only)</th>
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<tr>
<td>Medication Name</td>
<td>Dose &amp; Frequency</td>
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Continue medications on next pages if needed

Notes:__________________________________________________________________________

Allergies:_____________________________________________________________________

Administered by(Camp Use Only):________________________________________________

BIA-MO Sunnyhill Adventures Camp Packet 2020: Page 29
Sunnyhill Adventures
Camp Medication Administration Record

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<thead>
<tr>
<th>Camper’s Full Name</th>
<th>Camp Dates</th>
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Continue medications on next pages if needed

Notes: __________________________________________________________

Allergies: ______________________________________________________

Administered by(Camp Use Only): ________________________________
### Sunnyhill Adventures
#### Camp Medication Administration Record

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<thead>
<tr>
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**Notes:**

Allergies:

Administered by (Camp Use Only):

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BIA-MO Sunnyhill Adventures Camp Packet 2020: Page 33
Van Transportation Request
*(only fill out if needing to be picked up by van)*

Camper’s Name ________________________________

Contact Person on travel dates

Sunday, June 21:  Name ________________________________ Mobile #________________

Friday, June 26:  Name ________________________________ Mobile #________________

Sunnyhill Camp van transportation is available from:

St. Louis – BIA-MO Office, 2265 Schuetz Rd., St. Louis, MO 63146
Kansas City – Hillside Christian Church, 900 NE Vivion Rd., Kansas City, MO 64118
St. Joseph – Mosaic Hospital, Plaza 3 Parking Lot, 5325 Faraon St., St. Joseph, MO 64506
Columbia – Paquin Towers, 1201 Paquin St., Columbia, MO 65201

Round-trip van fee is $25 per person.

**VAN:** For van arrivals, please indicate which location Camper will be boarding:

[ ] St. Louis  [ ] Kansas City  [ ] St. Joseph  [ ] Columbia

Camper will bring:  [ ] Wheelchair (electric)  [ ] Wheelchair (manual)  [ ] Scooter  [ ] Walker

Is Camper able to transfer from wheelchair or scooter to a bus seat?  [ ] Yes  [ ] No

Times for transportation will be sent the week of June 8, 2020.

Please mail this form to

Sunnyhill Adventures
PO Box 246, Dittmer, MO 63023
DONATION RESOURCES FOR BIA-MO CAMP FEES

We want you to be able to attend Camp! If you need assistance in paying your Camp Fee, this sheet offers resources.

The Senate Bill 40 of Missouri may offer local funding for persons with developmental disabilities, including individuals who sustained a brain injury at age 21 or younger. Below are the counties of Missouri with a Senate Bill 40 Board:


For your county’s contact information, please visit https://macdds.org/services/member-county-boards/.

When you call:
Introduce yourself and let them know you are seeking funding for the Brain Injury Association of Missouri Donald Danforth Jr. Wilderness Camp.

Ask if they financially support recreational or socialization programs.
If they do support such programs, ask:
1. What is their process to help with your Camp Fee?
2. What percentage of the Camp Fee do they cover?
3. Do they cover bus transportation to and from Camp?

Information They May Need to Know for Eligibility or Camp Registration:
1. Camp Fee amount to enter is $550 (the actual amount charged to BIA-MO)
2. Age at which your brain injury occurred
3. Summary of your special needs

Community Organizations
Service, civic, veterans and community organizations may have funding for local residents to participate in various programs, such as the BIA-MO Camp. Examples of such groups are Rotary, Lions, or Kiwanis Clubs. Local volunteer or business groups may also be able to help.

Church or Congregation
Your church or groups within your congregation may be able to make a donation. Submit a write-up for your congregation’s newsletter or bulletin to request assistance.

Businesses
Restaurants, gas stations, service providers, doctors, or other businesses you frequent may be able to help with a donation.

Family and Friends
They know firsthand how much joy Camp brings. They may be able to help.

Camp donations can be mailed to BIA-MO, 2265 Schuetz Road, St. Louis, MO 63146. Note: Record Camper’s name in the memo line.
Dear Friend:

The Brain Injury Association of Missouri (BIA-MO) hosts a camp each year, which I enjoy as a survivor of brain injury. This camp is the only week-long organized outdoor camp in Missouri for adults with brain injury. Please help me be able to attend through a donation towards my Camp Fee. The BIA-MO Camp will be held on June 21 – 26, 2020. Your donation is tax deductible through the Brain Injury Association of Missouri.

My fee for Camp in 2020 will be $390. This is a fraction of the actual costs to the Brain Injury Association, who subsidizes the rest of the price. Costs of Camp include activities, cabin accommodations, meals, assistance, staff, transportation and more.

There are many activities at Camp, including boating, swimming, zip-lining and talking with old and new friends. The nights are filled with dances, karaoke, games and more. Camp is very fun and I look forward to attending each year.

The Mission of the Brain Injury Association of Missouri is to reduce the incidence of brain injury; to promote acceptance, independence and productivity of individuals with brain injury; and to support their families, caregivers and the community.

Additional programs of BIA-MO include educational programs for survivors of brain injury and their families, caregivers and the community. There are also support groups throughout the State to give survivors and their families the opportunity to share their challenges, frustrations and accomplishments with others who truly understand, since they too are living with brain injury.

Thank you for your consideration to help me attend the BIA-MO Donald Danforth Jr. Wilderness Camp through a donation towards my 2020 Camp Fee. Your check should be made payable to BIA-MO. In the Memo of the check please include my name. I can submit your donation, or you may mail it to the Brain Injury Association of Missouri at 2265 Schuetz Road, St. Louis, MO 63146.

Sincerely,
Brain Injury Association of Missouri
Donald Danforth Jr. Wilderness Camp Donation Record Form 2020

Camper Name ____________________________________________

Contact Person for Additional Information ____________________________

Address ____________________________________________ Phone _______________________

City _______________________ State ______ Zip Code ___________ Alt. Phone _____________

Email ______________________________________________________

Please return this form, completed with the donations you have received, to ensure accurate recording of donations for your Camp and bus fee (if applicable).

Checks should be made payable to the Brain Injury Association of Missouri (BIA-MO).

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<thead>
<tr>
<th>Donor Name and Address</th>
<th>Amount Enclosed</th>
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Mail completed form to: BIA-MO, 2265 Schuetz Road, St. Louis, MO 63146 or bring to Camp and give to Maureen or Clayton. Memo of check should include the Camper’s name. Donors with complete information on this list will receive a letter from the Brain Injury Association for tax purposes. BIA-MO Tax ID: 43-1264556
2020 WALK-FLOAT-SWIM FUNDRAISER

Hello Camper!

This is Clayton Fenter. You might know me better as “that guy who spends time with us at Camp – the one who always wears a bandana so his bald head doesn’t get burned!” (I also hand out those neat prizes for doing laps during the week!)

Let’s do this event again!

This year we are having the 10th Annual “WALK-FLOAT-SWIM FUNDRAISER!!!”

During the week at Camp, you have the opportunity to walk, float and/or swim laps in the pool or on land to raise funds for the BIA-Missouri organization, for future Camp Scholarships, AND, you get some great exercise too!

The idea is to get your family, neighbors and friends (Facebook friends too) to sign up to support you. Bring your support form to Camp with you, and we will post your results each day. AND, there will be daily and end of the week prizes awarded for the most laps completed. Everyone who enters the event has several chances at winning! The prizes are really cool – you may recall seeing them last year!

Remember – you can choose to walk, float and/or swim laps in the pool, on land or in the air conditioned building. You will always have someone from the Camp or swim staff helping you too! Soooo, get with it!

See the next page for instructions (bring that form to Camp).

Please call the Brain Injury Association of Missouri if you have any additional questions. They can be reached at 314-426-4024 or 1-800-444-6443.

SEE YOU AT CAMP!!!

Clayton Fenter
BIA-MO Fundraiser - Walk, Float and Swim for BIA!

June 21 – 26, 2020

1. Have FUN, earn money for BIA-MO, and get some exercise!

2. Fill out the information below and get as many people as you can to support your efforts at Camp.

3. You can either do your laps in the pool, or use the marked trail at Camp to walk or wheel. Staff support is with you!

4. BRING THIS FORM WITH YOU TO CAMP. Your form will be authenticated and notarized with your total laps for the week, and returned to you. You can then present the form back to your supporters and collect their donations!

5. Make checks payable to the Brain Injury Association of Missouri, 2265 Schuetz Rd, St. Louis, MO 63146.

Camper Name ____________________________

<table>
<thead>
<tr>
<th>Supporter’s Name</th>
<th>Tel Number</th>
<th>Amt. per lap or Lump Sum</th>
<th>Total Laps</th>
<th>$ Total</th>
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BRING THIS FORM WITH YOU TO CAMP!