



The Hospital for Special Care Ivan Lendl Adaptive Sports Camp, a program of Hospital for Special Care Community Services, Inc., **will be held at Berlin High School, Berlin, Connecticut: August 5 - 9, 2019.**

Camp, offered free-of-charge to youth ages 6-19 living with physical disabilities, is held Monday – Friday from 9:00a.m. to 4:00p.m. Instruction is provided in a variety of sports such as tennis, track and field, basketball, and soccer. No previous sport experience is necessary. Campers are asked to bring their own wheelchair and other personalized adaptive equipment for greatest success. A number of sport wheelchairs will be available for trial use during camp, but are to be shared equally among all campers. **NEW** this year is an option for campers to select a “SPORTS INTENSIVE” week of camp that will provide opportunity for advanced skill development and focus on 1-2 sports with dedicated coaching staff and volunteers. See additional application for more information. **Coach review and authorization required for the sports intensive so get your application in early if you are considering this opportunity.*

The HSC Sports & Community Program Manager serves as the Camp Director, providing leadership and oversight. Support staff include: a registered nurse, coaches and program specialists with experience in adaptive sports and recreation and counselors who themselves are athletes living with physical disabilities. Additionally, camp relies heavily on volunteers from the community, of whom many have been associated with the camp since its inception.

REGISTRATION is easy. Please follow these steps:

- Step 1: Reserve your spot today by calling (860-832-6220) or emailing me that you are requesting a place so that I can reserve a spot for you: (jconnolly@hfsc.org)
- Step 2: Complete and return the Registration Form and Liability Release. ***(Registration is on a first-come, first-serve basis, with ALL FORMS DUE no later than JULY 20, 2019.)***
- Step 3: Complete and return the enclosed health/exam record by July 20, 2019. Note: Health Exam records are good for 3 years so if you have one dated within this time frame, you may use it. Campers who will be bringing medication to camp are required to complete an Authorization for medication administration form in addition to the medical form. ***Placement is contingent upon receipt of a completed Health Exam form signed by a physician, PA or APRN or RN.***

All registrants will receive a confirmation email that includes details such as acceptance, list of what to bring, a sample schedule and family and social opportunities during the week of camp.

Hospital for Special Care is very proud of the HSC Ivan Lendl Adaptive Sports Camp. It is so much more than sports skills acquisition. It's about relationships, independence and leadership skills that are acquired and the many positive memories that are made. Don't miss out on your opportunity to be involved.

Sincerely,

Janet

Janet Connolly, MS, CTRS
Sports & Community Program Manager
jconnolly@hfsc.org
Phone: (860)832-6220



ADAPTIVE SPORTS PROGRAMS



Date: _____

Participant Registration Form

Program(s): (Check all that apply)

- Chargers Indoor Wheelchair Soccer Team
Cruisers Track & Field and Racing Team
Hospital for Special Care Ivan Lendl Adaptive Sports Camp
Spokebenders Wheelchair Basketball Team
Junior Wheelchair Basketball with Ryan Martin Foundation
Inclusive Recreation Events
Wave Swim Team

Role(s): (Check all that apply)

- Athlete
Coach
Volunteer
Student Observer
Professional
Other: _____

PARTICIPANT INFORMATION

Name of participant – last, first, middle

Date of birth: ___/___/___ Age: _____ Height: _____ Weight: _____ Gender: M F

Home address Number and street City/State/Zip

(____) _____ (____) _____ Email address

PARENT INFORMATION (required for participants under 18)

Mother/legal guardian name (____) Cell phone (____) Other

Father/legal guardian name (____) Cell phone (____) Other

EMERGENCY CONTACT (other than parent/guardian)

Name (____) Phone Relationship to participant

Primary care physician name _____ Phone (____) _____

Insurance company name _____

Policy number _____ Policy holder's name _____

HEALTH HISTORY

Primary diagnosis _____ Date of onset _____

Secondary diagnosis _____ Date of onset _____

Please check and provide an explanation for any present or past conditions that apply below:

- | | | | | |
|--------------------------------------|---|-----------------------------------|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Communication | <input type="checkbox"/> Health | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Digestion | <input type="checkbox"/> Hearing | <input type="checkbox"/> Sensation | <input type="checkbox"/> Other (<i>please list below</i>) |
| <input type="checkbox"/> Bone/joint | <input type="checkbox"/> Elimination | <input type="checkbox"/> Heart | <input type="checkbox"/> Special diet | |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Emotional/mental | <input type="checkbox"/> Muscular | <input type="checkbox"/> Thinking/cognition | |
| <input type="checkbox"/> Circulation | | <input type="checkbox"/> Pain | | |

Explanation

Date of last tetanus shot/booster _____

Significant Medical Procedures (*Describe procedure and date*)

Medications (*Include name, dose, frequency for all prescriptions, emergency and over-the counter medications*)

Adverse Reactions (*Please list any adverse reactions to medications or environmental stimuli that could affect individual's participation*)

DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (*include assistance required or equipment needed*)

Physical Function (*i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding*)

Activity Restrictions

Psycho/Social Function (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

Toileting

Urinary: Continent Incontinent

Bowel: Continent Incontinent

Assistance required by participant/devices used

Barrier(s) to participation (Check all that apply)

- Adaptive Equipment
- Aide / "Buddy"
- Financial
- Overnight Lodging
- Transportation

GENERAL INFORMATION

How did you hear of Hospital for Special Care Adaptive Sports /Mentorship Programs? (Check all that apply)

Web site Newspaper Friend Brochure Therapy clinic School Physician office

Other _____

Have you participated in Hospital for Special Care programs before? Yes No

Do you participate in adaptive sports or mentorship programs outside of Hospital for Special Care programs?

Yes No If yes, what programs _____

What are your strengths? _____

Is there a special goal this year you would like to achieve while participating? _____

Do you have any concerns about participating? _____

DEMOGRAPHIC INFORMATION (requested on many grant applications that help fund the programs)

Which category best describes participant's race or ethnicity?

African American (not of Hispanic origin) Asian American or Pacific Islander

Caucasian/White (not of Hispanic origin) Hispanic Multiracial Other _____

Is participant a veteran? Yes No

What category best describes participant's annual household income? (Optional)

Less than \$24,999 \$25,000 to \$49,999 \$50,000 to 99,999 \$100,000 or more

Please return completed registration form to:

Janet Connolly, MS, CTRS, Sports & Community Program Manager
Hospital for Special Care Adaptive Sports
2150 Corbin Avenue
New Britain, Connecticut 06053

For questions please contact Janet Connolly:

Email: JConnolly@hfsc.org
Fax: 860.612.6368
Phone: 860.832.6220

FOR OFFICE USE ONLY

Date rec'vd: _____

Additional Forms	Date Sent	Date Rec'vd	Update
Aquatic Rehab Center Registration	_____	_____	_____
HSC Confidentiality Agreement	_____	_____	_____
HSC CRUISER Liability Waiver/Registration	_____	_____	_____
HSC Liability Waiver	_____	_____	_____
HSC Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Form	_____	_____	_____
HSC Ivan Lendl Camp Waiver/Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Authorization	_____	_____	_____
HSC Ivan Lendl Camp Prescription Authorization	_____	_____	_____

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