HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

**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 8 - 12, 2022.**

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, basketball, boccia, 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.

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: **Space is limited.** 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 ASAP. ***(Registration is on a first-come, first-serve basis).***
- Step 3: Complete and return the enclosed health/exam record ***by July 22, 2022.*** 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.***
- Step 4: Return all additional forms ***no later than JULY 27, 2022.***

All registrants will receive a confirmation email that includes details such as acceptance, list of what to bring, a sample schedule and updated COVID guidelines for the week of camp.

Hospital for Special Care is very proud of the HFSC 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.

Reach out with any questions that you may have.

Sincerely,

*Janet*

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

HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

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

(_____) _____ (_____) _____ _____

Home phone Cell phone 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:

| | | | | |
|---|---|---|---|---|
| ☐ Allergies | ☐ Communication | ☐ Health | ☐ Seizures | ☐ Vision |
| ☐ Behavioral | ☐ Digestion | ☐ Hearing | ☐ Sensation | ☐ Other *(please list below)* |
| ☐ Bone/joint | ☐ Elimination | ☐ Heart | ☐ Special diet | |
| ☐ Breathing | ☐ Emotional/ mental | ☐ Muscular | ☐ Thinking/ cognition | |
| ☐ Circulation | | ☐ 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 | _____ | _____ | _____ |

Revised 2/2019

**Participant Name:**_____

HOSPITAL FOR SPECIAL CARE
Adaptive Sports Program

## IVAN LENDL ADAPTIVE SPORTS CAMP
## RELEASE OF LIABILTY

## AND

## AUTHORIZATION TO USE AND DISCLOSE PHOTOGRAPHS AND RECORDINGS AND RELATED PERSONAL INFORMATION OF PARTICIPANT

I, the undersigned, give full permission for _____ (Name of Participant) to be observed and have photographic images taken of him/her while participating in activities of the **Hospital for Special Care Ivan Lendl Adaptive Sports Camp** (the "Camp") held on the campus of Berlin High School, Berlin, Connecticut.

I understand that photographic images may include still photographs, digital images, video filming or audio recordings, and other similar formats.

I further give permission to use and disclose my name and my child's/ward's name, as indicated: ____ full name, ____ first name only, and/or ____ initials only (hereinafter "name").

I further give permission to use or disclose to authorized third parties, including members of the public, such photographic image(s) and name for the following purposes:

- ☐ fundraising materials
- ☐ written publication(s) (for example, the entity's Annual Report)
- ☐ television or radio coverage
- ☐ advertising/marketing materials
- ☐ use on the entity's website
- ☐ public relations/media requests
- ☐ publication of research/education materials
- ☐ social media page (for example, Facebook)
- ☐ other:_____

Provide further details of intended use, if any: _____

If the purpose of this Authorization involves taking of photographic images for journalistic and/or media purposes (including print, television or electronic media), I further authorize representatives of the news media involved to observe the activities being conducted, and to discuss them with the Camp staff. I realize that the result of this observation may be publication or broadcast of facts concerning my child's/ward's medical condition.

I expressly waive any right to control copying, reproduction, or distribution of any photographic images taken in accordance with this authorization, and I expressly waive any right to any compensation whatsoever for any use of such photographic images.

I understand that this authorization is only for the specific, stated purposes. I understand that this authorization is valid and enforceable for a period of five (5) years from the date it is signed, but it may be revoked by me at any time upon written request to the Camp, except to the extent that action has been taken in reliance on this authorization.

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury while participating in activities at the Camp, I authorize representatives of Hospital for Special Care Ivan Lendl Adaptive Sports Camp to secure and retain medical treatment and transportation if needed.

I certify that I am over eighteen (18) years of age and have the legal right and authority to sign this form on my behalf or that of the Participant/child/ward named herein. I understand the meaning of this form, and I hereby release Hospital for Special Care Ivan Lendl Adaptive Sports Camp and its parent organization and affiliates (including Hospital for Special Care and Hospital for Special Care Foundation, Inc.), and their respective agents, servants, employees, physicians, officers, directors, and consultants from any claim or liability whatsoever in connection with the taking or use of photographic images and related observation, and any accompanying disclosures, publication, or broadcast of photographic images and/or the Participant's name or related health information or related material.

I further release and forever discharge and agree to indemnify and hold harmless Hospital for Special Care Ivan Lendl Adaptive Sports Camp and its parent organization and affiliates (including Hospital for Special Care and Hospital for Special Care Foundation, Inc.), and their respective agents, servants, employees, physicians, officers, directors, and consultants from any claims and demands of any and every kind and character for any injury to myself, my child's/ward's person or damage to property as a result of participation in activities of the Camp.

_____ _____

Signature of Participant (or Parent/Guardian or Personal Representative) Date

Relationship to the Participant, if applicable: _____

_____ _____

Witness: (If Participant is physically unable to sign) Date

Updated: 5/25/2022