

Camper Name:



Cincinnati Children’s Hospital Medical Center

♥♥ Heart Camps ♥♥
Family Retreat Weekend
Camp Joyful Hearts



1. I understand that my participation in programs offered by Cincinnati Children’s Hospital Medical Center (CCHMC) is based on a “Challenge by Choice” philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.
2. I am aware that experiential outdoor pursuits such as climbing, hiking, high ropes courses, ground initiatives, and other activities provided by CCHMC at Joy Outdoor Education Center for which I and/or my child have enrolled entails certain risks.
3. Therefore, for myself/my child, I expressly, knowingly and voluntarily assume all risks involved in my participation, and do hereby release CCHMC and its members, trustees, officers, employees, and independent contractors and agents from any and all liability, damages, costs, and expenses arising out of or relating to bodily injury, loss of life or personal property that may occur as a result of participating in this program.
4. I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding on the parties during the entire period of participation in the said program.
5. Authorization for treatment- I hereby give permission to the medical personnel selected by the CCHMC to arrange necessary related transportation for this participant and assist with the prescription and over-the-counter medication if needed. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by CCHMC or Camp Joy to secure and administer treatment, including hospitalization, for the person named above.
6. I acknowledge that the accommodations consist of large cabins which will house several families. CCHMC encourages all participants to bring only the minimum articles and personal items necessary for a comfortable weekend. CCHMC assumes no responsibility or liability for any lost, missing or stolen personal items.
7. I understand that the participants on the Retreat Weekend will be made up of patients and families from The Heart Institute. CCHMC assumes no responsibility or liability for any injury suffered as a result of the behavior of other participants.
8. I give my consent for myself or my child to be photographed or videotaped for general camp, website, and/or CCHMC publicity.

Required: Signature of participant

Date

Signature of parent (If participant is under 18)

Note: This participant shall not be permitted to participate in the following activities:

****DO NOT USE THIS FORM FOR RESEARCH PURPOSES OR TO RELEASE COPIES OF THE MEDICAL RECORD****

This form gives permission for Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose (release) the health information of the individual below as follows:

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Address City State/Zip

Primary contact e-mail: _____ Phone: () _____

Information To Use/Disclose	CCHMC may use/disclose the following health information about the individual: <i>(Select all that apply)</i>		
	<input type="checkbox"/> Photographs	<input type="checkbox"/> Name and age	<input type="checkbox"/> Admission, discharge, or treated/released status
	<input type="checkbox"/> Video recordings	<input type="checkbox"/> Parent/guardian names	<input type="checkbox"/> Diagnosis, treatment, prognosis
	<input type="checkbox"/> Audio recordings	<input type="checkbox"/> City of residence	<input checked="" type="checkbox"/> All of the above
	<input type="checkbox"/> Other: _____		

Purpose of Use/Disclosure	CCHMC may use/disclose this health information for the purposes described below: <i>(Select all that apply)</i>
	<input type="checkbox"/> CCHMC communications, such as for marketing, advertising, public relations, fundraising, or other related purposes. This may include publications (print or electronic), presentations (at public or private events, on television), or internet sites (e.g., CCHMC websites, partner websites, or social media sites).
	<input type="checkbox"/> The media, including print or television journalists.
	<input type="checkbox"/> Professional audiences, such as publications (print or electronic), presentations or related internet sites.
	<input checked="" type="checkbox"/> All of the above
<input type="checkbox"/> Other: _____	

By signing below, I authorize CCHMC to use and/or disclose the health information specified in this authorization and confirm to the best of my knowledge that I am legally authorized to represent the interests of this individual.

- CCHMC will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization.
- The health information used and/or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. CCHMC is not responsible for the use of information, in whole or in part, by third parties.
- Any photos, images, or other representations specified above become the property of CCHMC or its representatives.
- This authorization is given without promise of compensation. The parent/legal guardian and the individual release to CCHMC any right, title and/or interest of any kind they may have in the information or images produced.

As stated in the Notice of Privacy Practices, I understand that I may withdraw this authorization at any time. Notification of withdrawal must be done in writing and sent to the CCHMC Health Information Management (HIM) Department, 3333 Burnet Avenue, ML 5015, Cincinnati, OH 45229. This authorization will not be withdrawn or expire for situations where CCHMC has already taken action as described in this authorization. This authorization will only expire if revoked by me in writing as stated above.

Signature: _____ Date: _____

Printed name: _____

This form must be signed and dated to be valid. If the individual is an emancipated minor or 18 years of age or older, s/he is required to sign the authorization.

A copy of this authorization must be provided to the individual completing this form.

CCHMC USE ONLY	Department requesting authorization: _____
	*Note: The original, signed authorization must be sent to the HIM Department Attn: ECRM (MLC 5015) within 2 weeks of obtaining signature. The department obtaining this authorization must also retain a copy, either on paper or electronically, for internal tracking purposes.





JOY OUTDOOR EDUCATION CENTER (dba Camp Joy)

RISK & RELEASE FORM

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT.**

Name: _____ Date: _____ Male Female I am a:
Address: _____ City _____ State _____ Zip _____ Check: Over 18 Over 21
Phone Number: _____ Email: _____

Emergency Contact Name/Relationship: _____ Phone #s _____

Emergency Contact Name/Relationship: _____ Phone #s _____

List any allergies & or dietary restrictions*: _____

List any physical restrictions*: _____

Please list any activities/programs the participant is NOT PERMITTED to participate in*: _____

*Additional space for allergy, diet, physical, activity, or program restrictions:

Acknowledgment of Risk and Release

INSTRUCTIONS: Please read this form carefully and contact Camp Joy with any questions.

I understand that completing and signing this form is a prerequisite for my or my child's participation in Camp Joy's programs.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (dba Camp Joy) and Joy Outdoor Education Center Foundation, Inc., is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

Activities: I am aware that experiential, outdoor pursuits for which I have enrolled such as living history reenactments (Ex. Underground Railroad), hiking, walking on uneven ground, high ropes challenge courses, ground initiatives, mountain biking, archery, swimming, and other activities at Camp Joy entail certain risks. Camp Joy has a number of high ropes elements. High ropes courses can include poles, ropes, cables and platforms on which participants move with and without the assistance of staff and other participants. The level of exertion required for the activities will be similar to a day of moderate to strenuous exercise. Activities are explained by staff, and belay or other support systems may be used. Activities vary in height and difficulty.

Risks: I understand and acknowledge that experiential education including high ropes courses and other Camp Joy activities involve risks which could result in injury, tripping, falling, broken bones, burns, death, or damage to my property. I may be in situations in which I depend on others for my physical well-being. The risks

described and others are inherent in Camp Joy activities and without them the activities would lose their essential character and value.

Camp Joy recommends that those with heart conditions, high blood pressure, back or neck issues refrain from full participation in high ropes experiences and physically spotted activities. Expectant mothers (without a specific medical release) are not permitted to fully participate at height on ropes courses or with spotted activities.

Release: I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates (including the Warren County Astronomical Society with respect to our Observatory), representatives, successors, and assigns, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether known or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any Camp Joy program, including, but not limited to any physical injury, psychological injury, or loss of life or personal property that may occur as a result of participating in this program.

Photography: I understand that photography commonly occurs during Camp Joy programs. I consent for myself and/or my child/minor of legal responsibility to be photographed for general Camp Joy use, including program and/or agency printed/internet publicity. Check this box to decline the photo release.

Authorization for Treatment: I give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant, and for the visiting organization or Camp Joy to secure and administer treatment, including hospitalization, for the participant named below.

Signature: I have read, understand, and accept the terms and conditions stated in this Risk and Release Form. The named participant has permission to engage in program activities, except as noted.

I understand that my signature on this Release form will remain valid for one year of programs at Joy and I acknowledge my obligation to inform Camp Joy in advance of any changes in the child's/participant's health that may affect the child's/participant's ability to participate in activities in any way. I certify that the information my child or I have provided is complete and accurate.

_____ Signature of participant (REQUIRED)	_____ Date	_____ If participant is under 18, (Signature of Parent or Guardian is REQUIRED)	_____ Date
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(Print Name Please)

2015 CAMP JOY / OHIO SUMMER FOOD SERVICE PROGRAM APPLICATION

FOR OFFICE USE ONLY:
 \$ _____ Monthly Income
 _____ Approved
 _____ Denied
 Signature of Authorized Official

Joy serves nutritious meals as part of the federally funded Summer Food Service Program for Children.
 Thank you for your time to help JOY in this reimbursement program!

COMPLETE & SIGN SECTION 1, 2 or 3

I certify that all of the below information is true and correct. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws

Camper's Name _____

1 FOR CHILDREN RECEIVING FOOD STAMPS OR OWF

____ Yes, I received Food Stamp or OWF benefits for the child listed above this month and request meal benefits.

Food Stamp Case Number (10 digit #)

Your 10 digit case number can be found on your certification letter from SNAP or OWF.

OR

OWF/TANF Identification #

 Signature of Adult Household Member Date

OR

2 FOR FOSTER CARE CHILDREN

____ Yes, the camper is under the legal responsibility of a human service agency and is living in our household.

Personal Use Income of Foster Child:

\$ _____
 "O" if the child has no personal use income.

 Signature of Adult Household Member Date

Income Eligibility Information for Section 3:

REDUCED INCOME ELIGIBILITY GUIDELINE – 185% Guidelines

To be effective from July 1, 2014 through June 30, 2015

Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

Household Size	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	\$21,590	\$1,800	\$900	\$831	\$416
2	29,101	2,426	1,213	1,120	560
3	36,612	3,051	1,526	1,409	705
4	44,123	3,677	1,839	1,698	849
5	51,634	4,303	2,152	1,986	993
6	59,145	4,929	2,465	2,275	1,138
7	66,656	5,555	2,778	2,564	1,282
8	74,167	6,181	3,091	2,853	1,427
For each additional household member, add	+ 7,511	+ 626	+ 313	+ 289	+ 145

OR

3 FOR CHILDREN NOT CURRENTLY RECEIVING FOOD STAMPS OR OWF

LIST <u>ALL</u> HOUSEHOLD MEMBERS' NAMES	Gross Monthly Earnings	Monthly Welfare/ Child Support / Alimony / OWF	Monthly Pensions/ Retirement / Social Security	Monthly Other income

 Signature of Adult Household Member _____
 Last 4 Digits of Social Security # _____
 Date

Section 9(d) of the National School Lunch Act requires that the primary wage earner, or adult household member signing the application, include their social security number but if you refuse, your child may not receive free meals. The social security number may be used to identify you for verifying the information reported on this application. Verification may include audits; investigations; contacting the state employment security office, Food Stamp or welfare office, and employers; and checking the written information provided by the household to confirm the information received. If incorrect information is discovered, a loss of benefits or legal action may occur. These facts must be told to the household member whose Social Security number is reported on this form.

NON-DISCRIMINATION: No child will be discriminated against because of race, color, national origin, sex, age or disability. This facility is operated in accordance with USDA policy, which does not permit discrimination because of race, color, national origin, sex, age or disability. Any person who believes that he or she has been discriminated against in any USDA related activity should write immediately to the Secretary of Agriculture, Washington D.C., 20250.