



## BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

### 16<sup>th</sup> Annual BIANC Retreat

*Hosted by The Brain Injury Association of North Carolina*

- **WHEN:** September 17-19, 2010
- **WHO:** Survivors of Brain Injury, family members and friends
- **WHAT:** A weekend of camp, fun and fellowship for survivors.
- **WHERE:** Camp Carefree-Stokesdale, NC
- **WHY:** To have fun!
- **HOW:** Campers, Caregivers/Family members complete the registration forms and send to BIANC with a check for \$20.00 per person payable to BIANC. (\$18.00 for BIANC members) You will receive a confirmation on your registration with directions, schedule and what to bring.

BIANC  
PO Box 10912  
Raleigh, NC 27605

Please carefully read the enclosed application forms. Forms must be filled out for each person attending camp, including caregivers/family members. If you need multiple applications, please feel free to photocopy any forms provided.

**Horse Back Riding:** EVERY person that wants to participate in the horseback riding must have Pages 7 & 8 completed by a physician.

For information regarding registration or BIANC membership, please call the Raleigh BIANC office at  
**(919) 833-9634 or 1-800-377-1464**  
[bianc@bianc.net](mailto:bianc@bianc.net)

### **The deadline for applications is August 17, 2010!**

If forms are incomplete, they will be returned to you.  
We will fill the 120 camper spaces on a first come-first served basis.  
Limited scholarships are available for the \$20 camper fee.



# BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

## CAMP APPLICATION

**Please complete one form for each person attending this BIANC event.  
*Deadline for registration is 4 weeks before the event. (August 17, 2010)*  
Please get applications in as soon as possible as space is limited!**

Application Date: \_\_\_\_\_

Camp Date: September 17-19, 2010

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Nickname) \_\_\_\_\_

Check the box that applies to you:

Survivor of BI and their Caregiver/Family

Caregiver for: \_\_\_\_\_

Volunteer Professional: \_\_\_\_\_  
(Name profession above)

Student: \_\_\_\_\_  
(Name major above)

**Special Sleeping Needs:** Examples: Couples, need electrical outlet by bed, anyone you specifically need to be with in same cabin. If yes, please explain on back of this form.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Day) \_\_\_\_\_ (Night) \_\_\_\_\_ (Cell) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Male Female

Email Address: \_\_\_\_\_

Emergency Contact During Camp; Name: \_\_\_\_\_

Contact's Telephone:  
(Day) \_\_\_\_\_ (Night) \_\_\_\_\_ (Cell) \_\_\_\_\_

T-Shirt Size: Medium Large XLarge XXLarge XXXLarge

In planning for camp we seek to provide the highest level of care and safety possible. In order to do this we need to know as much information as possible about the functional levels and specific needs. Please provide all information that might be of value to camp staff working with the applicant during the event. **All applicants**, please fill out the application in its entirety. Regardless of how many years you have attended camp, we want the most accurate information to ensure a safe and fun event for everyone.

**Official Use Only**

Received \_\_\_\_\_ Payment \_\_\_\_\_ Notified \_\_\_\_\_  
Check# \_\_\_\_\_ Amount \_\_\_\_\_

## **Medical Information**

All medical information must be complete before application will be processed.

**Medical History:**

Please list all current and prior pertinent conditions and surgeries.

Diagnosis	Date	Surgery	Comments
Ex. Brain Injury	10/15/1979	Shunt put in	Protect shunt site, headaches
Ex. Diabetes	6/7/1982		Food restrictions

Please list all doctors currently treating applicant

Name	Specialty	Phone	After Hours #

**Seizure History:**

Does this applicant have a history of seizures?  Yes  No  
 If Yes, what type? \_\_\_\_\_ How often \_\_\_\_\_ Date of most recent seizure \_\_\_\_\_  
 Are there any "auras" or behaviors/events that occur before or after seizure takes place?

**Medications:**

Is the applicant capable of administering his/her own medication? Yes No

ALL MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION PACKING/BOTTLE

Please document all medications applicant will take during the time they are at camp:

Medication	Dosage	Times Administered	# of pills per dose	Pill Color	Special Instructions	Purpose of Medication
Ex. Klonopin	1mg	9am,3pm	1	Blue	Crushed in applesauce	Anxiety

Are there any known allergies? (Including food, insects, medications, etc.)

No  Yes If yes state allergy and nature of reaction and treatment:

Are there any special precautions that should be taken for the applicant?  No  Yes  
 If yes, describe in detail.

Are there particular habits/concerns the camp staff should be aware of (food dislikes, sleeping patterns, wandering, inappropriate language or behavior)?

While at camp there will be male and female volunteers as well as campers. Does the applicant have difficulties with maintaining appropriate male/female relationships? If so, explain.

Please indicate any problem areas for the applicant (check all that apply)

\_\_\_\_\_ Paralysis \_\_\_\_\_ Short term memory \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Agitation  
\_\_\_\_\_ Attention span \_\_\_\_\_ Behavioral \_\_\_\_\_ Speech

Please note any further information we may need to know about any of these problem areas.

Does the applicant use any of the following: \_\_\_\_\_ Cane \_\_\_\_\_ Leg Braces \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair

If the applicant uses a wheelchair, which type? \_\_\_\_\_ Manual \_\_\_\_\_ Power

Can the applicant propel indoors/outdoors independently? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, what assistance may be required?

Is the applicant able to transfer him/herself from chair to bed, bath, or toilet? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, what assistance is required?

Do you have any special dietary needs the MUST be met at camp? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a service animal that will be accompanying you to camp? \_\_\_\_\_ Yes \_\_\_\_\_ No

**\*If yes you must provide a copy of certification of service animal and current immunizations when you submit this application.**

Please address the following if applicable; provide details and strategies that may be helpful to staff in interacting with the applicant.

Cognitive Issues:

Physical Issues:

Emotional Issues:

Communication Issues:

Please indicate the level of assistance the applicant requires for each of the following:

Level of Assistance	None	Minimal	Moderate	Total
Activity				
Dressing/Undressing				
Eating				
Toileting				
Bathing/Hygiene				
Walking				



## Horseback Riding at Camp

**ALL** camp participants **MUST** complete the attached forms in order to participate with the horseback riding activities. The camper or Guardian/parent will sign this page and take the next two pages to your physician for their signature and review. Return these forms with your camp application to BIANC:  
PO Box 10912, Raleigh, NC 27605

Those camp participants interested in horseback riding at camp must have a completed:

**Horseback Riding At Camp Form (Horsepower/Camp Carefree)**

**Rider's Medical History**

**Physician's Statement**

**Without these forms, campers CANNOT ride on a horse.**

I hereby acknowledge that I have been advised of the risks involved in participating in horseback riding or the activities sponsored by the Brain Injury Association of North Carolina. I also acknowledge that I have taken into account the impairments (if applicable) of \_\_\_\_\_

Participant's Full Name

And hereby release HorsePower, Camp Carefree, BIANC, its volunteers, staff and agents from any and all liability/claims of any nature arising out of participation in this retreat.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian (if applicable)

\_\_\_\_\_  
Date

## Rider's Medical History and Physician's Statement

(To be completed by physician in order to participate in horse riding activities at camp Sept. 18, 2010)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of onset: \_\_\_\_\_

**\*\*For Persons with Downs Syndrome:**

Cervical X-ray for atlantoaxial Instability: \_\_\_\_\_ Positive \_\_\_\_\_ Negative X-Ray date \_\_\_\_\_

Tetanus Shot: Yes No Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Seizure Type \_\_\_\_\_ Controlled \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Please indicate if patient has a problem and /or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

**Mobility:** Independent Ambulation \_\_\_\_\_ Yes \_\_\_\_\_ No Crutches \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Braces \_\_\_\_\_ Yes \_\_\_\_\_ No Wheelchair \_\_\_\_\_ Yes \_\_\_\_\_ No

Please indicate any special precautions: \_\_\_\_\_

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh in the medical information above against the existing precautions and contraindications.

Physician's Name (please print) \_\_\_\_\_

Physician Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form please note whether these conditions are present and to what degree.

### **Orthopedic**

Spinal Fusion  
 Spinal Instabilities/Abnormalities  
 Atlantoaxial Instabilities  
 Scoliosis  
 Kyphosis  
 Lordosis  
 Hip Subluxation and dislocation  
 Osteoporosis  
 Pathologic Fractures  
 Coxas Arthrosis  
 Heterotopic Ossification  
 Osteogenesis Imperfecta  
 Cranial Deficits  
 Spinal Orthoses  
 Internal Spinal Stabilization Devices

### **Neurologic**

Hydrocephalus/shunt  
 Spina Bifida  
 Tethered Cord  
 Chiari II Malformation  
 Hydromyelia  
 Paralysis due to spinal cord injury  
 Seizure Disorders

### **Medical/Surgical**

Allergies  
 Cancer  
 Poor endurance  
 Recent surgery  
 Diabetes  
 Peripheral Vascular Disease  
 Varicose Veins  
 Hemophilia  
 Hypertension  
 Serious Heart Condition  
 Stroke (Cerebrovascular Accident)

### **Secondary Concerns**

Behavior problems  
 Age under two years  
 Age under four years  
 Acute exacerbation of chronic disorder  
 Indwelling catheter