Dear Camp Carpe Diem Family:

Congratulations and welcome to Camp Carpe Diem 2014 to be held June 26th, 27th, and 28th! We are very excited about the ninth year of camp and have planned some exciting things for you.

We are enclosing a number of forms for you, your child, and your physician to complete. Every form must be completed, signed, and returned to Uinta County School District #4 by June 1, 2014! New this year, there will be a $10 registration fee that is refundable when the camper arrives to camp. We recommend that each family complete their forms and return them to us as soon as possible. In addition to other useful information, a checklist with helpful hints is provided in the handbook for your convenience.

Please read the Camp Brochure completely, as it contains important information regarding camp, directions for dropping off and picking up your camper, and even what to pack. Note: In order for your child to attend camp, all medication, in original containers, must be turned into the camp medical staff at registration. You will have the opportunity to talk with the nurses and medical staff at this time for special instructions. If your child has a Respite worker, we strongly recommend that he/she attend the camp with your child to assist in the various activities. Both the Respite worker and your child will greatly benefit from this experience.

All forms should be mailed to:

Lori Jensen or Chris Stoddard
Uinta County School District #4
Special Services Department
PO Box 130
Mountain View, WY 82939
Phone: 307.782.3136, extension 4206
Fax: 307-782-6466
Email: jensenlo@uinta4.com
stoddardc@uinta4.com

If you have any further questions or concerns regarding Camp Carpe Diem, please feel free to contact me. I look forward to visiting with you on the opening day of camp.

Sincerely,
Camp Carpe Diem Coordinators
Camper’s Name ____________________________________________

Mailing Address ____________________________________________
Street or PO Box City State Zip Code

Parent Email Address:________________________________________

Sex: Male ____________ Female ____________ Age: ________ Birthdate: _________________

Ethnicity: Caucasian ________ Native American ________ African American ________
Hispanic ________ Asian ________ Other _____________________

School ____________________________________________ Grade next fall _________________

Lives with both parents ____________ Lives with father_________ Mother________ Guardian_______

Mother’s Name ___________________ Home Phone ____________ Other Phone ____________

Place of Business Address, City, State, Zip

Position Business Phone Fax Number

Father’s Name ___________________ Home Phone ____________ Other Phone ____________

Place of Business Address, City, State, Zip

Position Business Phone Fax Number

Emergency Notification

In the event we are unable to contact parent(s) in an emergency, we will call the following persons regarding your child. If parents are out of town during the days of camp, we must have a number where they may be reached.

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Home Phone</th>
<th>Other Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Emergency Contact</td>
<td>Home Phone</td>
<td>Other Phone</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Camp Carpe Diem provides equal opportunity to all qualified persons without regard to race, color, creed, sex, or national origin.

Return this form to:
Uinta County School District #4
Camp Carpe Diem
% Lori Jensen or Chris Stoddard, Special Services Department
PO Box 130
Mountain View, WY 82939
Camp Carpe Diem
CAMPER PHYSICAL FORM
(To be reviewed and completed by a medical professional such as MD, PA-C or NP and returned)

Camper’s Name _______________________________________________________

Sex: Male_______  Female ________  Age: ______  Ht _______  Wt _______  B/P _________

Allergies _____________________________________________________________

System Assessment

Eyes _______________  Ears _______________  Nose _______________  Throat _______________
Heart _______________  Lungs _______________  Abdomen _____________  Skin _______________

Extremities ____________  Abnormal Findings _____________________________

Seizure Classification: Type #1 __________________________________________

Type #2 ____________________________________________________________

Other chronic or recurring illnesses or handicapping conditions ________________

_______________________________________________________________________________

Describe any behavior disturbance ____________________________________________

Current anti-seizure therapy ______________________________ Medication ___________

Vagus Nerve Stimulator____________________ Ketogenic Diet _______________________

List all Medications the Camper is currently taking

All medications must arrive to camp in their original containers!!

*If medication changes are made prior to camp, please bring an updated medication list to camp!!

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Frequency</th>
<th>Blood Level</th>
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</tbody>
</table>

Special instructions/comments/limitations _______________________________________

_______________________________________________________________________________

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

_______________________________________________________________________________

Examining Physician
(MD, Do, NP, or PA)  Date  Phone Number  Fax Number

I request that the camp medical personnel or designee administer the medication as directed above to my child __________________. I certify that the above medication list is correct and accurate.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Guardian Signature ___________________________________  Date ______________

Additional comments:
Camp Carpe Diem
CAMPER MEDICAL FORM
(To be completed by parent and return)

Camper’s Name _______________________________________________________

Last    First    Middle Initial

Current medical diagnoses or condition? ________________________________________________

Will your camper bring his/her own respite worker to camp? YES   NO

If yes, please list name and contact number for respite worker_______________________________

HEALTH

Child’s health in general: Excellent _______ Average _______ Below Average ____________

Does your family currently have medical/hospital insurance?   YES       NO          Carrier_____________________

Policy Number ___________________________ Group Number ___________________________

Name of Policy Holder ___________________________________ Relationship to Camper _________________

SEIZURE SUMMARY

When was your camper’s seizures first diagnosed? ____________________________________________________

Type of Seizures: Tonic-Clonic (Grand Mal) _______ Complex Partial _______ Absence (Petite Mal) _______

How frequent? __________________ Date of last seizure _______________ Length of seizure _______________

How do you handle your camper’s seizures? ____________________________

DESCRIPTION OF TYPICAL SEIZURE, if any

Sudden fall, cry, rigidity followed by muscle jerks           Brief staring spells

Walks around                                             Repetitive or aimless activities

Possible loss of bladder or bowels                       Some confusion, headache and fatigue

Other (please describe)__________________________________________

Does your camper usually get a special warning? Yes _____ No _____ Please describe ________________________________

Has your camper had status epilepticus (unstoppable seizures)?   Yes ______ No __________

How many times? ___________ When was the last time? _____________

HEALTH HISTORY Please check all that apply and review with your camper’s physician at time of examination.

_____ Asthma              _____ Cerebral Palsy              _____ Mental Retardation          _____ Diabetes

_____ Heart defect/disease    _____ Frequent Ear Infections    _____ Bleeding/clotting disorder

Other chronic or recurring illnesses or handicapping conditions ____________________________________________

CHILDHOOD DISEASES Please record date (month and year) of infection.

_____ German Measles        _____ Mumps          _____ Chicken Pox          _____ Diabetes

_____ Other – Please Describe ______________________________________________

IMMUNIZATION HISTORY Please record date (month and year) of basic immunizations. You can obtain a copy of this

record from your school nurse or physician.

_____ DPT Series            _____ DPT Booster        _____ Measle Vaccine (live)

_____ Polio OPV (Sabin)      _____ Polio Booster      _____ Mumps Vaccine (live)

_____ German Measles        _____ Tetanus Booster     _____ Tuberculin Test

_____ Other

MISCELLANEOUS

Please list any and all allergies (including drug, plants, foods, etc.) _________________________________________

Operations or serious injuries (include dates) _____________________________________________________________

Does your camper wear glasses, contacts, hearing aids, retainers, etc.? _______________________________________

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by

the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.    Guardian

Signature __________________________________________ Date __________________
ALL MEDICATION NEEDS TO ARRIVE AT CAMP IN ITS ORIGINAL CONTAINER!!
Please attach a picture of the camper to this form to assist staff with identification.

Camp Carpe Diem
CAMPER PROFILE
(This form will be shared with your child’s camp staff prior to camp)

Camper’s Name – What he or she likes to be called? __________________________

Does your camper have special fears, emotional or behavioral problems? If so, please explain.

How do you deal with behavior problems?

Does your camper need a special cabin assignment?

Has your camper been away from home, without parents, for more than one night? __________________

Sleep habits: Light ________ Heavy ________ Sleepwalker ________ Nightmares ___________

Bedwetting________ If so, how is this handled at home? ___________________________

Does your child wear?  Glasses_____ Contacts_____ Hearing Aides_____ Retainers_____ Other_____

Please indicate your camper’s t-shirt size

<table>
<thead>
<tr>
<th>Children’s</th>
<th>Adult’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Small</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Large</td>
<td>Large</td>
</tr>
</tbody>
</table>

I would like to order extra camp T-shirts for $15.00: How many shirts? ____

What sizes? ______

CAMPER PARTICIPATION CONSENT

I understand and certify that my camper, ________________________________________ may participate in Camp Carpe Diem and its activities at Uinta County Youth Camp, and that his/her participation is completely voluntary. I have familiarized myself with the programs and activities at Camp Carpe Diem in which my camper will participate. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not be limited climbing, hiking, and team sports. I acknowledge that although Uinta County School District # 4, Uinta County, and the sponsors have taken safety measures to minimize the risk of injury to camp participants, the sponsors cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for Camp Carpe Diem. I have received approval from a doctor authorizing my camper to participate in Camp Carpe Diem and its activities at the Youth Camp.

_____________________________________________ __________________________
PARENT OR GUARDIAN (FATHER) DATE

_____________________________________________ __________________________
PARENT OR GUARDIAN (MOTHER) DATE
Camp Carpe Diem

NATIONAL GUARD PARTICIPATION CONSENT

I understand and certify that my camper, ______________________________________ may participate in the National Guard activities at Uinta County Youth Camp, and that his/her participation is completely voluntary. I have familiarized myself with the programs and activities the National Guard sponsors at Camp Carpe Diem in which my camper will participate. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not be limited climbing, hiking, and team sports. I acknowledge that although Uinta County School District # 4, Uinta County, and the sponsors have taken safety measures to minimize the risk of injury to camp participants, the sponsors cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for the National Guard activities at Camp Carpe Diem. I have received approval from a doctor authorizing my camper to participate in the National Guard activities during Camp Carpe Diem at the Youth Camp.

______________________________
PARENT OR GUARDIAN (FATHER) DATE

______________________________
PARENT OR GUARDIAN (MOTHER) DATE

PERMISSION FOR TREATMENT AND TRANSPORT

The health history described in the Camp Carpe Diem Camper Information and Health History Form is correct to the best of my knowledge. In the event of an accident or injury involving my camper, ______________________________, I authorize the Camp Carpe Diem staff, medical staff, volunteers or other executors to obtain medical treatment for my camper and to transport if needed. I give my permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my camper named above. I understand that payment of any medical expenses incurred by my child will be my responsibility.

______________________________
PARENT OR GUARDIAN (FATHER) DATE

______________________________
PARENT OR GUARDIAN (MOTHER) DATE

LIABILITY RELEASE

I, the undersigned, understand that occasionally accidents occur during camp activities, and that participants may sustain serious personal injury and property damage as a consequence thereof. Knowing the risks of camp activities, I nevertheless agree to assume those risks. By signing this liability release, I intend to legally bind myself, my minor children, my heirs, executors, and administrators, and anyone claiming by, through or under any of them. I HEREBY RELEASE AND FOREVER DISCHARGE UINTA COUNTY SCHOOL DISTRICT #4, UINTA COUNTY, AND THE SPONSORS AND EACH OF THEIR OFFICERS, DIRECTORS, EMPLOYEES (THE “RELEASED PARTIES”) FROM ALL CLAIMS, CAUSES OF ACTION OR DAMAGES ARISING OUT OF ANY INJURY, ILLNESS, OR LOSS OF ANY KIND, THAT MAY BE SUSTAINED BY MY CAMPER DURING OR RELATE TO MY CAMPER’S ATTENDANCE AT CAMP CARPE DIEM AT UINTA COUNTY YOUTH CAMP, WITHOUT REGARD TO THE CAUSE OR CAUSES OF SUCH INJURY, ILLNESS, OR LOSS, EVEN IF SUCH CLAIM, CAUSES OR ACTION, OR DAMAGES ARISE FROM THE NEGLIGENCE OR CARELESSNESS OF THE RELEASED PARTIES.

______________________________
PARENT OR GUARDIAN (FATHER) DATE

______________________________
PARENT OR GUARDIAN (MOTHER) DATE
Camp Carpe Diem

RELEASE OF INFORMATION TO CAMPER’S PHYSICIAN

(Please contact us if completing this form is difficult, we will work with you to ensure appropriate forms are completed.)

I hereby authorize the camp medical staff to disclose any and all records pertaining to my camper’s physician. I, on behalf of my camper, hereby release Uinta County School District #4, Uinta County, and the sponsors from all legal responsibility and liability, which may arise from the release of these records to the physician(s) below.

Physician Name _______________________________________ Phone ________________________
Address ___________________________________________ State ___________ Zip Code _________

Type of Physician (neurologist, pediatrician, etc.) ____________________________________________

Physician Name _______________________________________ Phone ________________________
Address ___________________________________________ State ___________ Zip Code _________

Type of Physician (neurologist, pediatrician, etc.) ____________________________________________

PARENT OR GUARDIAN (FATHER) ________________________________ DATE

PARENT OR GUARDIAN (MOTHER) ________________________________ DATE

MEDIA RELEASE

I hereby give Uinta County School District #4, Uinta County, and the sponsors the right to interview and/or take photographs, audio, or audio-visual recordings of my camper, ________________________________, to be used in promotional, educational, or fundraising materials including, but not limited to videotapes, pamphlets, and brochures. Uinta County School District #4, Uinta County, and the sponsors of the event shall have the right to use photographs or other images of my child in promotional, educational, or fundraising materials. I hereby release Uinta County School District #4, Uinta County, and the sponsors from any all claims arising out of such photography, reproductions, publication or exhibition as is authorized by Uinta County School District #4, Uinta County, and the sponsors. I acknowledge that I have legal authority to sign this form on behalf of the above-mentioned child.

PARENT OR GUARDIAN (FATHER) ________________________________ DATE

PARENT OR GUARDIAN (MOTHER) ________________________________ DATE
COMMON GROUND

DS/USA & COMMON GROUND OUTDOOR ADVENTURES INSURANCE WAIVER & RELEASE OF LIABILITY FORM and MEDIA RELEASE FORM

Please note: there are two places on this sheet that require a signature

DS/USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM

In consideration of being allowed to participate in any way in DISABLED SPORTS USA’s & COMMON GROUND OUTDOOR ADVENTURES programs, related events, and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or legal guardian I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe, to the best of my ability, that anything is unsafe, I and/or the minor participant will immediately advise DISABLED SPORTS USA of such condition(s) and refuse to participate.

2. Acknowledge and fully understand that I and/or the minor participant, will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the condition of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.

3. Assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.

4. Release, waive, discharge and covenant not to sue DISABLED SPORTS USA, COMMON GROUND OUTDOOR ADVENTURES, its affiliated clubs, their representative administrators, directors, agents, coaches, and other employees of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and lesasers of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

X __________________________________________________________________________
Participant's Name (PLEASE PRINT CLEARLY) Signature Date

FOR PARTICIPANTS UNDER THE AGE OF 18

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

X __________________________________________________________________________
Parent's Signature & Emergency Phone Name & Date (PLEASE PRINT CLEARLY)

MEDIA RELEASE FORM

Name______________________ Age________ Male____ Female____

(PLEASE PRINT CLEARLY)

MEDIA/PHOTO WAIVER: I hereby authorize and give my full consent to Common Ground & Disabled Sports USA to copyright and/or publish any and all photographs, videotapes and/or film in which I appear while attending an event. I further agree that Common Ground & DS/USA may transfer, use or cause to be used, these photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, and television programs without limitations or reservations.

X __________________________________________________________________________
Signature of Participant/Guardian