Camp Civitan 2022 Fall Schedule

Camper Name:	Gender: ☐Male ☐Female ☐ Non-Binary	Age:
Parent/Guardian Name(s):		
Parent/Guardian Phone Number(s):		
Parent/Guardian Email(s):		
Name of Person Responsible for Pick Up & Drop Off:		
Phone:	Email:	

Additional Information:

- Does your camper utilize a wheelchair? ☐Yes or ☐No (If yes, ☐Manual Wheelchair or ☐Motorized Wheelchair)
- Is this your camper's first time at Camp Civitan? ☐Yes or ☐No
- Does your camper have a bunk preference? ☐Top ☐Bottom
- Does your camper require transportation to/from Camp? ☐Yes ☐No, I will be dropping off and picking up at Camp.

FALL 2022 CAMPS

To register for a fall camp session, please complete and return this form, ensure all paperwork is up-to-date, and wait for your reservation confirmation. ***Camp session requests are not guaranteed until a confirmation is received****, and DDD authorizations must be confirmed at least one week prior to the camp start date.*

I'd Like to Register for:	Dates	Days	Check-In/Check-Out	Weekend Theme	Private Pay	Respite Hours	Activity Fee
Session 1 ☐	**Sept. 16 - 18**	3	Fri. 8 am - Sun. 5 pm	**Camp Jurassic** *16 & Up	☐$540	☐36	$50
Session 2 ☐	**Sept. 23 - 25**	3	Fri. 8 am - Sun. 5 pm	**The Wizarding World of Civitan** *16 & Up	☐$540	☐36	$50
Session 3 ☐	**Oct. 7 - 9**	3	Fri. 8 am - Sun. 5 pm	**Civitan Explorers** Under 18	☐$540	☐36	$50
Session 4 ☐	**Oct. 17 - 21**	5	Mon. 8 am - Fri. 5 pm	**Civitan Adventure Club** *16 & Up	☐$900	☐60	$50
Session 5 ☐	**Oct. 21 - 23**	3	Fri. 8 am - Sun. 5 pm	**Halloween Town** *16 & Up	☐$540	☐36	$50
Session 6 ☐	**Nov. 4 - 6**	3	Fri. 8 am - Sun. 5 pm	**Fall Festival** *16 & Up	☐$540	☐36	$50
Session 7 ☐	**Nov. 18 - 20**	3	Fri. 8 am - Sun. 5 pm	**Star Spangled Campers** *16 & Up	☐$540	☐36	$50
Session 8 ☐	**Dec. 16 - 18**	3	Fri. 8 am - Sun. 5 pm	**Santa's Workshop** *16 & Up	☐$540	☐36	$50
Session 9 ☐	**Dec. 28 - 31**	4	Wed. 8 am - Sat. 5 pm	**Winter Wonderland** *16 & Up	☐$720	☐48	$50

Below are just a few of the things you or your camper can expect to experience while at Camp Civitan.

- **Transportation**- This service is limited and **reserved on a first come, first serve basis.**
- **Permanent Features**- Miniature golf course, hay wagon, outdoor theater, TotTurf® multiplex, field house, greenhouse, playground, and new GaGa ball octagon.
- **On-Site Programming**- Sports, games, art, outdoor adventures, and entertainment programs.
- **Ongoing Field Trips**- Fishing at a local lake, Bearizona, community events and/or festivals.
- **Nighttime Activities**- Karaoke, skit performances, carnival games, themed dances, barbeques, campfires, and hayrides.
- **Guest Speakers & Instructors**- Special instructors and other area musicians and/or entertainers.
- **Socialization**- Campers develop friendships, create endless memories, gain social skills and independence.
- **Scholarships**- Need-based financial assistance may be available, please contact our office for more information.

Please Note: Pick-ups & drop-offs will only occur at Civitan Village unless other prior plans have been made with the Camp Director. ***If a camper arrives late to Camp Check-in, the Parent/Guardian will be responsible for transporting the camper to Williams, AZ for the camp session.***

I, the ***Parent/Guardian*** *will contact the* ***Support Coordinator*** *to arrange for Camp Civitan, Inc. to receive DDD authorization of hours at least one week prior to the camp start date. If DDD does* ***not*** *authorize hours prior to the camp session, I understand that I am* ***fully responsible*** *for* ***all camp fees.***

Parent/Guardian *Initials: _____ Date: _____*

2022 FALL CAMP DESCRIPTIONS

September 16 – 18 (3 Days): Camp Jurassic
Travel back in time with us to an era millions of years ago when Dinosaurs roamed the earth and even Arizona! Your days will be filled with Dino-riffic activities and a prehistoric field trip for a truly epic weekend!

September 23 – 25 (3 Days): The Wizarding World of Civitan
Calling all witches and wizards! Civitan's School of Magic is open once again for year two of your magical training. We'll concoct potions, learn new spells, and return to the pitch to play the most popular sport in the magical world. If you're a returning student, remember to bring your house colors! If you are joining us for the first time, we welcome you to experience the MAGIC of camp!

October 7 – 9 (3 Days): Civitan Explorers (Under 18)
There's nothing better than exploring the wilderness! Join us for a fun-filled weekend of outdoor activities and exploration. Games, adventures, and experiences that are once in a lifetime are our specialty, and we want YOU to join us!

October 17 – 21 (5 Days): Civitan Adventure Club
Adventure is out there – let's go find it! If you love field trips, this camp is for YOU. Each day we will go on a different adventure, only returning to Camp to shower and sleep. Have you been bitten by the adventure bug? Sign up today!

October 21 – 23 (3 Days): Halloween Town
A Civitan classic, where we celebrate the sweet, the scary, and even the silly! Join us at this spirited camp for a spooktacular weekend full of tricks, treats, and fun! Remember to bring your costume for our Halloween bash!

November 4 – 6 (3 Days): Fall Festival
Do you love sweater weather? Join us as we give thanks and enjoy all Camp has to offer this Fall season, including festive food, *pumpkin spice*, and long walks in a forest of changing colors. It's getting cold up here, so don't forget to bring that sweater!

November 18 – 20 (3 Days): Star Spangled Campers
WE WANT YOU! This camp is all about the armed forces, past and present. Join us as we celebrate America and those who served as we partner with our Veterans to provide you with an experience like no other! And don't worry, we'll still have time for your favorite camp classics.

December 16 – 18 (3 Days): Santa's Workshop
Brr…It's cold in here! There must be some elves in the atmosphere! Kick off the holidays with a camp that's sure to make you merry and bright. Experience the magic of the season as we sip eggnog, sing Christmas carols, and deck all the halls! Bring your winter gear and get ready for a weekend filled with tinsel and joy.

December 28 – 31 (4 Days): Winter Wonderland
Do you have the post-holiday blues? Grab your gloves, your hat, and your coat, and join us for 4 days, and 3 nights at Camp Civitan where you can enjoy Northern Arizona's winter wonderland. We'll fill the last days of 2022 with cool activities, hot cocoa, and memories that will last a lifetime!

INTAKE AND APPLICATION COMPLETION INFORMATION

Programs of Interest

DTA ☐ DTS ☐ GSE ☐ HCBS ☐ CAMP ☐ RESPITE RANCH ☐

New Member Intake:
If your member has never attended Civitan, an intake interview will need to be scheduled for you and your member. This interview takes 30 minutes to 1 hour and allows our staff to get to know your member better and further assess their individual needs.

Application Completion:
Please ensure that all parts of the application have been completed and are submitted with no areas left blank. Many pages are double sided, please be sure and complete all items. **Only completed applications will be processed**. *A link to our fillable version is available on our website www.civitanfoundationaz.org

A completed application includes the following:

1. **Application Forms Completed by Parent/Guardian (pages 1-3 & 7-16)**
2. **Application Forms Completed by Physician (pages 5 & 6).** Parents/Caregivers are responsible for picking up the medical forms from the doctor's office and mailing or faxing them to our office prior to the start of a program.
3. **Photo**
4. **Copy of Current Insurance Card**
5. **Copy of Current Annual ISP and Behavior Modification Plan**

Application Instructions:
Please be sure to fill out each section in its entirety, making sure to leave no blanks or mark N/A on all areas not applicable.

1. **Critical Information (pages 1 & 2):** Fill in each section completely, sign and date page 2.
2. **Participation Waiver (page 3):** Initial each statement that you agree to and sign and date page 3.
3. **Physician Forms (pages 5 & 6):** Filled out by physician, be sure to have all medications listed on page 5 or attached list and make sure to circle 'Yes or No' for all medications on page 6.
4. **Psychotropic Medication Consent (page 7):** Only applicable if taking psychotropic medications, sign and date page 7.
5. **Notice of Privacy Practices (page 13):** You may keep the privacy practices information pages 9-12, only sign, date and submit the signature page 13.
6. **Statement of Member Rights (page 15):** Sign and date page 15.

All completed applications should be mailed to:
Civitan Foundation, Inc.
12635 N. 42nd Street
Phoenix, AZ 85032

or emailed to:
info@campcivitan.org

If you have any questions or concerns regarding any of the above processes or require additional information, please do not hesitate to contact us, (602) 953-2944.

CIVITAN FOUNDATION

COMPLETION INSTRUCTIONS

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CIVITAN FOUNDATION

INSTRUCTIONS: This application is to be completed by Parent/Guardian in entirety for all new members. Please ensure all medical forms and releases accompany this application.

Civitan Foundation, Inc.
12635 N. 42nd St.
Phoenix, AZ 85032

CRITICAL INFORMATION

Member's Name:_____ Gender:_____ Age:____ Birthdate:___/___/___
Address:_____ City:_____ State:____ Zip:_____ Phone: _____
Race: ☐ Caucasian ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Hawaiian/Pacific Islander

Is he/she Hispanic/Latino? ☐ Yes ☐ No *(Includes Mexican, Cuban, Puerto Rican, Central & South American or other Spanish culture or origin regardless of race).*
Support Coordinator:_____ Assist ID:_____
Office Phone:_____ Email:_____
Living Situation**:** ☐ At Home ☐ Residential (i.e. Group Home, ADH)
Contact Name/Agency:_____ Relationship:_____
Cell Phone:_____ Alt Phone:_____ Email:_____
Emergency Contact:_____ Relationship:_____
Cell Phone:_____ Alt Phone:_____ Email:_____

Guardianship

Guardianship Type: ☐ Self ☐ Other:_____
Guardian'(s) Name(s):_____ Relationship:_____
Cell Phone:_____ Alt Phone:_____ Email:_____
Guardian's Address:_____

HEALTH – MEDICAL

Medical

Insurance:_____ Policy #:_____ Phone:_____
Primary Care Physician:_____ Phone:_____
Other Health Insurance Information:_____
Diagnosis/Diagnoses:_____
Med Log Required: ☐ Yes ☐ No. Special Instructions:_____
Height:_____ Weight:_____ Eye Color:_____ Hair Color:_____ Unique Marks:_____
Participant has Allergies to: ☐ None ☐ Medications ☐ Food ☐ Bee Stings ☐ Seasonal ☐ Other
Specify:_____Reaction:_____
Recommended Response to Allergic Reaction:_____
Seizures: ☐ Yes ☐ No. **Last Seizure Date**:___/___/___ Triggers/Warning Signs:_____
Type:_____ Frequency:_____ Duration:_____
Description:_____
Recommended Response:_____
Vagus Nerve Stimulator: ☐ Yes ☐ No. Describe Magnet Use:_____
Assisted Devices: ☐ N/A ☐ Vision ☐ Hearing ☐ Dental ☐ Other:_____
Describe:_____
Protective Devices:☐ N/A _____
Instructions for Use:_____
Purpose:_____
Other Health Care Routines: ☐ N/A

Mobility

Balance While Standing: ☐ Excellent *(not an issue)* ☐ Moderate *(stumbles, etc.)* ☐ Poor *(very unsteady, falls)*
Utilizes Adaptive Aids for Balance: ☐ Yes ☐ No
Independent Mobility: ☐ Crawling/Scooting ☐ Kneeling ☐ Standing ☐ Walking ☐ Running ☐ Climbing
Mobility/Balance Aids: ☐ N/A ☐ Walker ☐ Cane ☐ Crutches ☐ AFOs ☐ Leg Braces ☐ Wheelchair
☐ Other *(Specify)*_____
Positioning Instructions: ☐ N/A _____
Lifting/Carrying Instructions: ☐ N/A _____
Swim Level: ☐ Non-Swimmer ☐ Beginner ☐ Intermediate ☐ Advanced
Life Vest Required: ☐ Yes ☐ No ☐ Deep Water Only (i.e. Boating or Lakes)

CIVITAN FOUNDATION

INSTRUCTIONS: This application is to be completed by Parent/Guardian in entirety for all new members. Please ensure all medical forms and releases accompany this application.

Civitan Foundation, Inc.
12635 N. 42nd St.
Phoenix, AZ 85032

Communication

Communication Skills: ☐ Complex Sentences ☐ Simple Sentences ☐ Signs ☐ Nods Yes/No ☐ Gestures
Communication Devices:_____

Diet

Food:

Check all that apply	Utensils	Cutting	Drinking	Acquiring	Other:
Independent	☐	☐	☐	☐	☐
Adaptive	☐	☐	☐		☐
Requires limited assistance	☐	☐	☐	☐	☐
Requires significant assistance	☐	☐	☐	☐	☐

Does Food Present a Choking Hazard: ☐ Yes ☐ No.
Required Food Consistency: ☐ Normal ☐ Chopped ☐ Pureed.
Tube Feeding *(Special instructions required)* ☐ Yes ☐ No. _____
Eating Disorder *(Describe on separate sheet)* ☐ Yes ☐ No. _____
Special Diet *(Please attach a separate sheet with further description)* ☐ N/A _____
Describe special fluids or systems for intake: ☐ N/A _____

Personal Care Skills

Check all that apply	Dressing	Toileting	Bathing	Dental	Menses	Shaving	Other*
Independent	☐	☐	☐	☐	☐	☐	☐
Requires prompting	☐	☐	☐	☐	☐	☐	☐
Requires limited assistance	☐	☐	☐	☐	☐	☐	☐
Requires significant assistance	☐	☐	☐	☐	☐	☐	☐

Other* Special Care Needs: ☐ N/A _____
Diapers/Pull-ups: ☐ Yes ☐ No. If yes, ☐ Day ☐ Night.
Bunk Preference: ☐ Top ☐ Bottom

Note: You are responsible for providing supplies for your member's personal care needs (i.e. diapers, pull-ups, wipes, pads, tampons, etc.). Please also send bed pads and extra bedding if needed for your member when sleeping away from home.

Is there any special training required ☐ Yes ☐ No.
Describe:

Behavioral Concerns

Brief Description	Approximate Frequency	Recommended Intervention
☐ Aggression		
☐ Self-Injurious		
☐ Property Destruction		
☐ Wanders		
☐ Sexual Self-Stimulation		
☐ Sexually Active		
☐ Sexual Acting Out		
☐ Other		

Behavior Treatment Plan: ☐ Yes ☐ No. Reason:_____
Fears: ☐ Loud Noise ☐ Large Groups ☐ Animals ☐ Bodies of Water ☐ Other_____
Positive Reinforcers for Member:

Day Program *(if other than Civitan)*

Day Program:_____ Type:_____
Program Address:_____ Phone:_____
Contact Name:_____ E-mail:_____

SIGNATURE

Guardian's Name:_____
Signature: _____ Date: :___/___/___

CIVITAN FOUNDATION

PARTICIPATION WAIVER

MEMBER'S NAME: _____DATE: _____

PLEASE AFFIRM EACH STATEMENT BY INITIALING NEXT TO THE NUMBER.

1. _____ I hereby represent that I am the parent or legal guardian of this member.

2. _____ I hereby give my consent for my under age member to attend the Civitan Foundation, Inc.'s (Civitan) programs with adults of all ages, this will include areas such as, but not limited to: all areas of rotation, lunch areas, bathrooms, recreational areas and transportation**.**

3. _____ **Photos/Media:** I grant permission to Civitan to use the likeness, voice and words of the participant in TV, newspaper, film/video, or other media, for the purpose of promoting Civitan programs (Choosing not to initial this section will restrict Civitan from utilizing photos or video clips of the member in any videos).

4. _____ **Search and Seizure:** As a condition of participation and in order to provide a safe environment for all members, Civitan enforces a policy of reasonable search and seizures of the person and or personal property in situations of suspected theft, illegal drugs, or possession of contraband items such as weapons, fireworks, or alcohol. I hereby consent to such reasonable search and seizure and waive all claims made against Civitan.

5. _____ **Contacting Outside Authorities/Agencies:** As a further condition to ensure the safety of all members, I authorize Civitan, its agents, and employees, to call appropriate agencies, including Child/Adult Protection Services, law enforcement agencies, and mental health providers if my member becomes violent or is a threat to his/ her own safety or the safety of others.

6. _____ **Waiver of Responsibilities:** I hereby release and discharge Civitan and any and all of its agents or affiliates, employees or volunteers from any and all claims, liabilities, demands or rights which I (we), or any friends or relatives, may have against said corporation, or any of its agents, affiliates, employees, or volunteers on account of, connected with, or growing out of, any injury, accident, loss, damage or suffering, I (we) may hereafter sustain while on the premises or property owned, leased, or used by Civitan, arising out of granting permission for all recreation programs or usage of the said premises, whether said property be known as Civitan or any other named designation or location.

7. _____ **Medication Administration:** I authorize the Civitan staff to administer prescribed medications to my member.

8. _____ **Medical Consent:** In the event I am unable to be reached, I authorize Civitan to seek necessary medical attention for my member in the event of an emergency. I further agree to pay for any prescribed medication or treatment my member may need.

9. _____ **Transportation:** I give permission for a Civitan, provider to transport my member on any and all Civitan programs, and if so authorized by the Director/Manager/Coordinator or persons in charge.

10. _____ Should it become necessary for my member to be picked up from Camp, or any Civitan function, for any reason, I will make provisions to promptly pick them up from the activity site.

11. _____ I have fully disclosed my member's health conditions, including any propensities towards violent behavior and authorize Civitan to share this information with its staff.

12. _____ I hereby authorize the release of any and all pertinent information regarding my member to Civitan

13. _____ I agree to notify Civitan Foundation, Inc. with any changes that need to be made to this application.

14. _____ I hereby certify that to the best of my knowledge, all of the information provided in the application is true and complete.

I have read and understand the above statements. I agree to the Acceptance Conditions above.

Signature: _____ Date: _____

* Civitan does not discriminate against members based on gender, sexual orientation, gender expression, zip code, race or ethnicity.

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CIVITAN FOUNDATION

PARTICIPANT MEDICAL EXAM – SIDE A

FORM MUST BE COMPLETED BY A PHYSICIAN

Member Name: _____ Date: _____
Date of Birth: _____ Gender: _____ Height: _____ Weight: _____
Primary Disability: _____
Secondary Disability: _____
If intellectually challenged, give functioning age: _____ Are immunizations current? ☐Yes ☐No
Previous illness, conditions, or characteristics (Check all that apply):

☐Asthma
☐Heart Disease/Condition
☐Epilepsy
☐Seizure Type: _____
Frequency: _____ Duration: _____
☐Emotional/Behavioral Difficulties
☐Diabetes
☐Stroke: When? _____
☐Cancer: Remission? _____
☐Communicable Disease
☐Other Psych. Disorders
☐Eating Disorder
☐Autism
☐Special Issues _____
☐Noise Issues _____
☐OCD
☐ADD/ADHD
☐Recent serious illness/surgery
☐Recent minor illness/ailments

☐In the last 12 months, seen a professional to address mental/emotional concerns?
☐Had a significant life event that continues to affect the participant's life?
*Please explain any checked boxes: _____
_____
_____
_____
Allergies/Sensitivities (including medications):_____
Other pertinent diagnoses and/or current treatments:_____
Any prescribed meal plan or dietary restrictions: _____
Hearing Capacity: _____ Vision Capacity: _____
Is participant cleared for 7,000 feet elevation? ☐Yes ☐No
ACTIVITY LEVEL ADVISED: I approve supervised camping activities, including participation in, but not limited to, arts and crafts, Go-Karts, recreation, overnight campouts & swimming. ☐Non-strenuous ☐Minimum ☐Moderate ☐Full

CURRENT MEDICATIONS including routine Over The Counter and Prescriptions

Current Medication Name	Dosage (How much?)	Frequency (Times given)	What is medication for?

If needed you may attach a list of medications, please be sure that your physician signs the list as well.

Statement of Physician: I have examined participant _____. I have found no evidence of communicable disease and found him/her to be in satisfactory condition to participate in Civitan programs to:

A. _____ full extent without restrictions
B. _____ limited extent. Conditions as follows:_____

Signature of Physician: _____ Date: _____

Please complete both sides of form in its entirety.

CIVITAN FOUNDATION

PARTICIPANT MEDICAL EXAM – SIDE B

FORM MUST BE COMPLETED BY A PHYSICIAN

Civitan will not administer any over the counter medications unless this form has been filled out by your physician. The Arizona State Department of Health requires an individualized set of standing orders for each attending member. These standing orders specify which over-the-counter medications may be administered to an individual member and under what conditions. This form pertains to only over-the-counter medications, and must be completed and signed by a physician, physician's assistant, or nurse practitioner. Medications must come with the member in original bottles and containers.

Please circle Yes/No for each item on this list.

INDIVIDUALIZED ORDERS FOR:

Name: _____ Age: _____ Weight: _____

Drug Name	Route Please circle preferred	Dosage	Schedule and Indications	Member Health-Care Provider Order		Comments
Tylenol (Acetaminophen)	PO (Chewable Tabs, Elixir)	Per Label Instructions by Age/Weight	Q 4 hr prn for Pain or Fever > _____°F	Yes	No	
Motrin (Ibuprofen)	PO (Chewable Tabs, Sus-)	Per Label Instructions by Age/Weight	Q 6 hr prn for Pain or Fever > _____°F	Yes	No	
Robitussin	PO (Syrup)	Per Label Instructions by Age/Weight	Q 4 hr prn for Cough	Yes	No	
Mylanta	PO (Chewable Tabs, Liquid)	Per Label Instructions by Age/Weight	TID-QID prn for Stomach Upset	Yes	No	
Tums	PO (Chewable Tabs)	Per Label Instructions by Age/Weight	BID-TID prn for Stomach Upset	Yes	No	
Benadryl (Diphenhydramine HCL)	PO (Elixir or Tabs)	Per Label Instructions by Age/Weight	Q 4-6 hr prn for Allergy	Yes	No	
Sudafed (Pseudoephedrine)	PO (Tabs)	Per Label Instructions by Age	Q 4-6 hr prn for Sinus Congestion	Yes	No	
Midol	PO (Chewable Tabs)	Per Label Instructions by Age/Weight	Q 4-6 prn for Menstrual Symptoms	Yes	No	
Aleve (Naproxen)	PO (Tabs)	Per Label Instructions by Age/Weight	Q 12 hr prn for Pain or Arthritis	Yes	No	
Imodium AD (Loperamide)	PO (Tabs)	Per Label Instructions by Age/Weight	1 caplet after 1st BM, and ½ caplet after each subsequent loose BM	Yes	No	
Prune Juice/ Prunes	PO	4 oz or 5-10 prunes	No BM in 2 days	Yes	No	
Milk of Magnesia	PO (Liquid)	1 oz @ AM/HS	No BM in 3 days	Yes	No	
Glycerin Suppository	PR	1/HS		Yes	No	
Pepto-Bismol (Bismuth Subsalicylate)	PO (Liquid)	Per Label Instructions by Age	Q ½ -1 hr as needed	Yes	No	
Vitamin _____	PO (tabs, gummies)	Age/Weight		Yes	No	
Vitamin _____	PO (tabs, gummies)	Age/Weight		Yes	No	
Other				Yes	No	

Doctor's Name:_____ Phone #: _____

Signature:_____Date:_____

In case of medical emergencies we will contact 911 or transport to the nearest urgent care facility or hospital.

CONSENT TO ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS

I, (myself or the guardian) of: _____, give consent
(*Member's name)*

1. To the administration of: _____
   (Name of medication)
   For the prescribed purpose of: _____

   Prescribed by: _____
   (Prescribing Physician/Agent)

   With a maximum dosage of _____, for a time period not to exceed 12 months.

2. To the administration of: _____
   (Name of medication)
   For the prescribed purpose of: _____

   Prescribed by: _____
   (Prescribing Physician/Agent)

   With a maximum dosage of _____, for a time period not to exceed 12 months.

3. To the administration of: _____
   (Name of medication)
   For the prescribed purpose of: _____

   Prescribed by: _____
   (Prescribing Physician/Agent)

   With a maximum dosage of _____, for a time period not to exceed 12 months.

4. To the administration of: _____
   (Name of medication)
   For the prescribed purpose of: _____

   Prescribed by: _____
   (Prescribing Physician/Agent)

   With a maximum dosage of _____, for a time period not to exceed 12 months.

It is my understanding that such medication has been prescribed by a licensed physician who has made careful diagnosis and evaluation and is committed to the monitoring and possible future reduction or elimination of the medication as future needs indicate.

I have received information on the possible side effects and it is my understanding that any possible side effects will be reported by myself or Civitan Foundation Staff to the physician immediately.

Member/Guardian Signature: _____ Date:_____

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CIVITAN FOUNDATION

NOTICE OF PRIVACY PRACTICES

Effective: June 13, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

This notice will tell you how we may use and disclose protected health information about you.
Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In the header above, that information is referred to as "medical information." In this notice, we simply call all of that protected health information, "health information."

This notice also will tell you about your rights and Civitan's duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights. If you have any questions about this Notice, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

How We May Use and Disclose Health Information About You

- **For Treatment**
  We may use and disclose health information about you so we can be paid for the services we provide to you. This can include billing a third party payee, such as Medicaid or other state agency (for example, the state's Office of Mental Retardation), or your insurance company. For example, we may need to provide the state Medicaid program information about the services we provide to you so we will be reimbursed for those services. We also may need to provide the state Medicaid program with information to ensure you are eligible for the medical assistance program.

- **For Payment**
  We may use health information about you to provide, coordinate or manage the services, supports, and health care you receive from us and other providers. We may disclose health information about you to doctors, nurses, qualified mental retardation professionals (QMRPs), psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in supporting you or providing care. We may consult with other health care providers concerning you and, as part of the consultation, share your health information with them. For example, staff may discuss your information to develop and carryout your individual service plan. Staff may share information to coordinate needed services, such as medical tests, transportation to a doctor's visit, physical therapy, etc.

- **For Health Care Operations**
  We may use and disclose health information about you for our own operations. These are necessary for us to operate CIVITAN and to maintain quality for our patients. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our compliance.

- **How Will We Contact You**
  Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see "Right to Receive Confidential Communications" in this Notice.

- **Civitan's Directory**
  We may include your name, your location in our facility, your condition described in general terms in our directory while you receive services. This information may be released to people who ask for you by name. If you do not want to be included in our facility directory, or you want to restrict the information we include in the directory, you must notify our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

- **Disclosures to Family and Others**
  We may disclose to a parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you, health information about you that is directly relevant to that person's involvement with the services and supports you receive or payment for those services and supports. If there is a family member, other relative or close personal friend that you do not want us to disclose health information about you too, please notify our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

- **Disaster Relief**
  We may use or disclose health information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a parent/guardian, personal representative, family member, other relative, close personal friend, or other person identified by you of your location, general condition or death.

- **Public Health Activities**
  We may disclose health information about you for public health activities and purposes. This includes reporting health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease.

- **Victims of Abuse, Neglect or Domestic Violence**
  We may disclose health information about you to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you or your personal representative; or (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to others.

- **Health Oversight Activities**
  We may disclose health information about you to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government agencies.

- **Disclosures for Law Enforcement Purposes, Judicial and Administrative Proceedings**
  We may use or disclose health information about you when we are required to do so by law. We may disclose health information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal. We also may disclose health information about you in response to a subpoena, discovery request, or other legal process. We may also disclose health information about you to a law enforcement official for law enforcement purposes:
  a) As required by law;
  b) In response to a court, grand jury or administrative order, warrant or subpoena;
  c) About crimes that occur at our facility.

- **To Avert Serious Threat to Health or Safety**
  We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

- **Inmates and Persons in Custody**
  We may disclose health information about you to a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or (c) the safety, security and good order of the correctional institution.

- **Workers' Compensation**
  We may disclose health information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

- **Other Uses and Disclosures**
  Other uses and disclosures will be made only with your written authorization. Disclosures of psychotherapy notes, marketing disclosures and sale of protected health information require authorization. You may revoke such an authorization at any time by notifying the local Privacy Officer in writing at 12635 N. 42nd St., Phoenix, AZ 85032.

  If there is a breech and your protected health information is disclosed without consent, you will be notified of the breech.

Your Rights With Respect to Health Information About You

- **Rights to Request Restrictions**
  You have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close personal friend or any other person identified by you; or (b) to public or private entities for disaster relief efforts. To request a restriction, you may do so at any time. If you request a restriction, you should do so to us and tell us: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply (for example, disclosures to your spouse). However, we are not required to agree to any requested restriction.

- **Right to Receive Confidential Communications**
  You have the right to request that we communicate health information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at an alternative phone number. If you want to request confidential communication, you must do so in writing. Your request must state how or where you can be contacted.

- **Right to Inspect and Copy**
  With a few very limited exceptions, such as psychotherapy notes, you have the right to inspect and obtain a copy of health information about you. To inspect or copy health information about you, you must submit your request in writing. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

- **Right to Amend**
  You have the right to ask us to amend health information about you. To request an amendment, you must submit your request in writing. Your request must state the amendment desired and provide a reason in support of that amendment. If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreeance with our team.

- **Right to an Accounting of Disclosures**
  You have the right to receive an accounting of disclosures of health information about you. Certain types of disclosures are not included in such an accounting:

  A) Disclosures to carry out treatment, payment and health care operations;
  B) Disclosures of your health information made to you;
  C) Disclosures that are incident to another use or disclosure;
  D) Disclosures that you have authorized;
  E) Disclosures for our facility directory or to persons involved in your care;

  To request an accounting of disclosures, you must submit your request in writing. Your request must state a time period for the disclosures.

- **Right to a Copy of this Notice**
  You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain the most current version of our Notice of Privacy Practices over the Internet at our web site, www.civitanfoundationaz.org. To obtain a paper copy of this notice, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

Our Duties

- **Generally**
  We are required by law to maintain the privacy of health information about you and to provide individuals with notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of our Notice of Privacy Practices in effect at that time.

- **Our Right to Change Notice of Privacy Practices**
  We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice.

- **Complaints**
  You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by Civitan. To file a complaint with us, contact us. All complaints should be submitted in writing.

  To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him or her in care of: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

- **Questions and Information**
  If you have any questions or want more information concerning this Notice of Privacy Practices, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

Signature Page

By signing below, I acknowledge that I have been provided a copy of Civitan Foundation Inc.'s Notice of Privacy Practices statement and have thereby been advised of how health information may be used and disclosed by Civitan, and how I may obtain access to and control this information.

_____
Name of Member

_____
Name of Responsible Person

_____
Signature of Responsible Person

_____
Date

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CIVITAN FOUNDATION

STATEMENT OF MEMBER RIGHTS

You have the right to be free from personal and financial exploitation;
You have the right to a safe, clean, and humane physical environment;
You have the right to own and have free access to your personal belongings;
You have the right to have your friends;
You have the right to participate in social, religious, educational, cultural, and community activities;
You have the right to manage your personal finances and to be taught to do so;
You have the right to accomplish tasks with the least amount of assistance;
You have the right to privacy;
You have the right to choose the person to best assist you as indicated by your ISP;
You have the right to be treated with dignity and respect;
You have the right to be provided with choices and to express preferences which will be honored;
You have the right to make decisions about medical care, including the right to accept or refuse medical care;
You have the right to carry out an advance directive;
As a person with developmental disabilities, you have the rights, benefits and privileges guaranteed by the Constitution of the United States and the State of Arizona;
You have the right to be presumed legally competent regarding guardianship proceedings;
You have the right to be protected from exploitation and abuse;
You have the right to live in the least restrictive environment;
You have the right to receive a public education;
You have the right to fair and equitable employment;
You have the right to buy, lease, and rent real property without discrimination;
You have the right to be evaluated to receive the most appropriate services;
You have the right to receive a written ISP in which you have provided input, along with people you chose to participate to create an outcome based on the evaluation of your skills;
You have the right to review and/or change your ISP;
You have the right to participate in your initial evaluation, with your parent/guardian, and to be informed of your progress. In addition, you have the right to alternative service choice;
You and/or your parent/guardian have the right to remove services, except if services are assigned by the juvenile court;
You have the right to be free from mistreatment, neglect, and abuse;
You have the right to be free from unnecessary and excessive medication;
You and your parent/guardian have the right for these rights to be explained to you so that you fully understand;
You have the right as a "child" to appropriate services that are consistent with an ISP; services do not require the relinquishment or restriction of your parents/guardians rights;

_____	_____	_____
Member Name	Member Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

CIVITAN FOUNDATION

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