

# Initial Intake and Application

## New Vision Wilderness, LLC

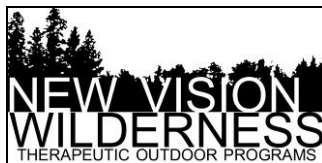
Client Name: \_\_\_\_\_

Course Dates: \_\_\_\_\_

This Packet includes:

Page 2	Contact Information
Page 3-5	Client History
Page 6	Liability Waiver
Page 7	Lyme Disease Waiver
Page 8	Rules Agreement
Page 8	Transportation Agreement
Page 9	Consent to Treat
Page 9-10	Information Release
Page 11-12	Physical Exam Form ( <i>To be completed by doctor for participants of expeditions more than 4 days</i> )
Page 13-14	Client Rights ( <i>Client Copy</i> )

*This application must be fully completed by the client and guardian in order to be processed. Please be as detailed and accurate as possible.*



**General Information:**

Client Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Gender: Male Female  
Address: \_\_\_\_\_  
Referring Agency/Individual: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Reason for referral: \_\_\_\_\_  
\_\_\_\_\_

**Contact Information:**

**Mother/Legal Guardian:** \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Father/Legal Guardian:** \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Siblings:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation: \_\_\_\_\_

**Other Emergency Contact:** \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Youth Profile:**

Strengths/Hobbies/Interests: \_\_\_\_\_  
\_\_\_\_\_

Needs and Deficits: \_\_\_\_\_  
\_\_\_\_\_

What do you hope to gain as a participant in our program? \_\_\_\_\_  
\_\_\_\_\_

**Mental Health History:**

A) What mental health issues contributed to you contacting us? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B) Check any of these problems or symptoms you have had recently:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Changes or Problems Eating	<input type="checkbox"/> Headache
<input type="checkbox"/> Tearfulness	<input type="checkbox"/> Changes or Problems Sleeping	<input type="checkbox"/> Fatigue/Tiredness
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Fears
<input type="checkbox"/> Loss of Interest in usual activities		

C) Any recent illnesses or deaths among your family or close friends?                      YES      NO  
If yes, please state when. \_\_\_\_\_

D) Any recent crises or major changes in your life?    YES      NO  
If yes, please explain. \_\_\_\_\_

E) Have you ever experienced any emotional, physical, or sexual abuse?                      YES      NO  
If yes, please explain. \_\_\_\_\_

F) Have you ever intentionally hurt yourself (cutting) or made a suicide attempt?                      YES      NO  
If yes, please explain. \_\_\_\_\_

G) Have you ever taken meds for anxiety, depression, sleep, or other emotional conditions?                      YES      NO  
If yes, please explain. \_\_\_\_\_

H) Have you ever been in counseling or psychotherapy before?                                      YES      NO  
Where and when? \_\_\_\_\_

I) Do you have any previous mental health diagnoses?    YES      NO  
Diagnosis: \_\_\_\_\_

J) Do you have any Phobias (intensive fears)?    YES      NO  
If yes, please explain. \_\_\_\_\_

K) Do you have any history of:

<input type="checkbox"/> Alcohol or Other Dg Abuse	<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Fire setting
--	--	---------------------------------------

\_\_Animal Cruelty  
\_\_Thoughts of suicide

\_\_Bed wetting  
\_\_Psychosis

\_\_Homicidal Ideation

Please explain any of the previously checked items above (most recent occurrence, frequency, etc.)

---

---

**Medical:**

A) Do you have any medical conditions? YES NO

If yes, please explain. \_\_\_\_\_

B) Have you have any type of physical disabilities? YES NO

If yes, please explain. \_\_\_\_\_

C) Have you ever been seriously injured? YES NO

If yes, please explain. \_\_\_\_\_

D) Can you swim? YES NO

E) Do you have any allergies? YES NO

If yes, please explain. \_\_\_\_\_

F) Do you have a history of Asthma? YES NO Do you use an inhaler? YES NO

G) Have you had any serous health conditions in the last 5 years? YES NO

If yes, please explain. \_\_\_\_\_

H) Health Insurance Information: (Please attach a copy of your insurance card.)

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Medication:**

Are you taking any medications at this time? YES NO

<u>Name/Type</u>	<u>Purpose</u>	<u>Dose</u>	<u>Time</u>
1. _____			
2. _____			
3. _____			
4. _____			

- I grant permission for the student to self-administer all prescription and non-prescription medications required by Doctor's Orders under staff supervision.
- I grant permission for the student to self-administer any other non-prescription medications as needed and under staff supervision.



**New Vision Wilderness  
Participant Release of Liability and Assumption of Risk Agreement**

Client Name: \_\_\_\_\_

Organization Name: \_\_\_\_\_

In consideration of being allowed to participate in the New Vision Wilderness, LLC program, related events and activities, I understand, acknowledge, appreciate, and agree that:

1. The risk of injury from the activities involved in this program is significant, including the potential for permanent paralysis and death.
2. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the New Vision Wilderness, LLC or others, and assume full responsibility for my participation in the program and related events and activities.
3. I willingly agree to comply with the terms and conditions for participation in the program and related events and activities. If I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention to the nearest official immediately.
4. I, for myself and on behalf of my heirs, assigns, personal representatives, and next of kin, hereby release, indemnify and hold harmless New Vision Wilderness, LLC, its officers, officials, agents, and/or employees, other participants, volunteers, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event, from any and all claims, demands, losses, and or liability arising out of or related to any injury, disability, or death I may suffer, or loss or damage to person or property, whether arising from the negligence of the New Vision Wilderness, LLC or otherwise, to the fullest extent permitted by law.

I have read this release of liability and assumption of risk agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement.

\_\_\_\_\_  
Client Signature                      Age                      Date

**For Parents/Guardians of participant of minor age, (under 18 at time of registration).**

This is to certify that I, as parent/guardian with legal responsibility for this participant, to consent and agree to his/her release as provided above of all 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 liability incidents to my minor child's involvement or participation in these programs as provided above, even if arising from the negligence of the Releasees, to the full extent permitted by law. I hereby consent for my child to receive medical treatment that may be deemed advisable in the event of my child's injury, accident or illness during this event or activity. This release, indemnification and waiver shall be construed broadly to provide a release, indemnification and waiver to the maximum extent permissible under applicable law.

I have read this release of liability and assumption of risk agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement.

\_\_\_\_\_  
Parent/Guardian Signature              Relationship              Date                      Emergency Phone Number(s)

**Photo Release:**

I grant New Vision Wilderness, LLC permission to photograph my son/daughter for promotional or educational purposes.

YES    NO (circle one)

**Permission to Travel:**

My son/daughter is permitted to travel to trip sites in transportation provided.

YES    NO (circle one)

## New Vision Wilderness Lyme Disease Awareness Form

Our backpacking trips are run in remote and forested areas of Wisconsin. Participants may be camping and hiking in areas that deer ticks can be commonly found. It is important to be aware of preventative measures in reducing the risk of acquiring Lyme disease and identification of early signs/symptoms of Lyme disease, a disease that is commonly carried by deer ticks.

**Prevention:**

Minimizing contact with areas where ticks are more common, such as tall grassy areas and over grown vegetation. Staying on trail as much as possible.

Wearing long pants and sleeves. Lighter colored clothes allow people to visibly identify ticks on their clothing.

Regular body checks, and removing any attached ticks.

Wearing of bug spray that contains DEET.

**Identification:**

If a person has hosted an infected deer tick, a red rash with a circular mark called a bullseye may be observed. Other early signs of Lyme disease include headache, fever, fatigue, stiff neck, and muscle or joint pain. Early identification of Lyme disease is important, as the administration of antibiotics early on will curb the continued symptoms of the disease.

By signing below I acknowledge that I have read this, and discussed precautionary measures with my son/daughter who will be participating in the Wilderness Program.

By signing this, I understand that my child is at risk for exposure to deer ticks, and I, for myself and on behalf of my heirs, assigns, personal representatives, and next of kin, hereby release, indemnify and hold harmless New Vision Wilderness, LLC, its officers, officials, agents, and/or employees, other participants, volunteers, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event, from any and all claims, demands, losses, and or liability arising out of or related to any injury, disability, or death I may suffer, or loss or damage to person or property, or if my child were to contract Lyme disease, whether arising from the negligence of the New Vision Wilderness, LLC or otherwise, to the fullest extent permitted by law.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**New Vision Wilderness  
Participant Rules Agreement**

I agree to adhere to the following rules of the New Vision Wilderness program:

- I will follow all instructions given by staff, interns, and volunteers.
- I will honor other participants' space, both emotionally and physically. I will not provoke other clients and will support them when they are struggling.
- I will not engage in any form of physical altercation.
- I will not possess any form of contraband. Contraband includes drugs, cigarettes, lighters/matches, alcohol, knives or any other weapons. They will be confiscated, and the police may be contacted.
- I will practice honesty throughout the program. I will not steal.
- I will participate in all groups and individual sessions.
- I will inform staff immediately if I witness any of the above violations.

I understand that NVW reserves the right to search clients and their belongings at intake, and at any time throughout the program at staff discretion based on safety concerns or probable cause.

I understand that if I violate any of the above rules, I may be expelled from the program immediately at the discretion of New Vision Wilderness staff. This may include immediate transportation back to my home. If the violation is severe in nature, the police may be contacted.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date

**Expulsion Transportation Agreement**

I, as the guardian of the program participant, understand that if the participant violates any of the above rules and is expelled, I may be asked to provide transportation back home.

\_\_\_\_\_  
Name of Guardian

\_\_\_\_\_  
Signature of Guardian





To: Physician of Choice  
From: New Vision Wilderness, LLC  
Re: New Participants Physical Examination

Participant: \_\_\_\_\_ Exam Date: \_\_\_\_\_

*Every participant of New Vision Wilderness expeditions must have a completed physical examination from an authorized physician. The exam must be current within 30 days of the beginning of the program. This form is required for participants of expeditions more than 4 days.*

Dear Doctor,

The above stated individual is going to participate in an outdoor adventure program. He/she may, on occasion, hike up to 10 miles a day in sometimes very hot/cold weather in wild and variable terrain. The participant will be carrying all of his/her equipment in a backpack and will be camping outdoors throughout the program.

We would appreciate your candid appraisal of the students' current health status. If you find the participant is 'fit' for this type of experience, please sign the physical form. If you find this participant 'un-fit' to manage such an experience, please be honest and open with the participant, the parents and New Vision Wilderness at this time. **Completed forms can be faxed to (414) 744-6288.**

Thank you,  
Drew R. Hornbeck  
Executive Director, New Vision Wilderness, LLC

---

**PHYSICAL EXAM FORM**  
(to be completed by physician)

Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse Rate: \_\_\_\_\_ Pulse Irregularities: Yes No

(over)

Check (√) if normal, describe ONLY if abnormal.

- Eyes \_\_\_\_\_
- Ears \_\_\_\_\_
- Nose \_\_\_\_\_
- Throat & Mouth \_\_\_\_\_
- Neck \_\_\_\_\_
- Thyroid \_\_\_\_\_
- Thorax & Lungs \_\_\_\_\_
- Heart \_\_\_\_\_
- Heart Murmur ( if present) \_\_\_\_\_
- Functional \_\_\_\_\_
- Peripheral Vessels \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Hernia \_\_\_\_\_
- Genitals \_\_\_\_\_
- Back \_\_\_\_\_
- CNS \_\_\_\_\_
- Lymph Nodes \_\_\_\_\_
- Skin \_\_\_\_\_
- Scars \_\_\_\_\_
- Extremities \_\_\_\_\_
- Shoulders \_\_\_\_\_
- Knees \_\_\_\_\_
- Ankles \_\_\_\_\_
- Feet \_\_\_\_\_
- Other \_\_\_\_\_

IMMUNIZATIONS: (list all dates) :

D.P.T. (series of 3) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Polio (series of 3) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MMR(series of 3) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HIB (18 mo.-5 yrs.) \_\_\_\_\_

Boosters \_\_\_\_\_

Boosters \_\_\_\_\_

Hepatitis B (series of 3) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Varicella (Chicken Pox) (after Jan. 1, 1998) \_\_\_\_\_

Tetanus \_\_\_\_\_

Please list any medical condition/medications NVW Staff should know about:

---



---

Please list any allergies (medications, food, plants etc.):

---



---

Expected reaction/treatment: \_\_\_\_\_

---



---

**TO BE COMPLETED BY DOCTOR:**

\_\_\_\_\_ was examined on \_\_\_\_\_ and found to be in satisfactory health and free from communicable disease. There is no reason that this child should not participate in activities at New Vision Wilderness.

\_\_\_\_\_  
Doctor Signature

## Client Copy

### **Client Rights and the Grievance Procedure for Community Services**

#### **PERSONAL RIGHTS**

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped or photographed unless you agree to it.

#### **TREATMENT AND RELATED RIGHTS**

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

#### **RECORD PRIVACY AND ACCESS**

Under Wisconsin Statute sec. 51.30 and HFS 92, Wisconsin Administrative code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats. and/or HSS 92, Wisconsin Administrative Code, is available upon request.

#### **GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS**

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

#### **GRIEVANCE RESOLUTION STAGES**

##### **Informal discussion (Optional)**

- You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

##### **Grievance Investigation-Formal Inquiry**

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.

- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

***Program Manager's Decision***

- If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

***County Level Review***

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

***State Grievance Examiner***

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, DSL, P.O. Box 7851, Madison, WI 53707-7851

***Final State Review***

- Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Supportive Living or designee. Send your request to: DSL Administrator, P.O. Box 7851, Madison, WI 53707-7851

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Note: There are additional rights within sec. 51.61(1) and HFS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to inpatient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or HFS 94, Wisconsin Administrative Code is available upon request.