

Dear Friends,

We are offering various life experiences for individuals with disabilities starting at age 8 and up at our Life Steps Camp this summer, “Lifestyles Adventures at the Ranch.” This year our camp will be held at the Medina Creative Ranch and the Medina Creative Treehouse “Pieh’s Paradise,” located at **5200 Lake Rd. Medina, OH 44256**. The facility is handicap accessible with an open plan for easy movement throughout. We will be providing access to the community through scheduled outings and field trips. All campers will also have an opportunity to participate in therapeutic horseback riding at Medina Creative Therapy Ranch. Lessons will be held outdoors if the weather permits or in our indoor riding arena during inclement weather. (If your child plans to ride horses you must fill out the enclosed Medina Creative Therapy Ranch horseback riding packet also).

We encourage all applicants to apply; however, please note we are not staffed to serve high medical needs. Our camp is staffed according to group ratio, and those requiring individual assistance would need to provide their own daily staff to meet their needs.

One of the goals of our program is to provide opportunities for individuals with disabilities in a home-like setting to prepare them for a future of as much independence as possible. By providing enriching experiences, we will lay a lifetime foundation for increased independence and future independent living transitioning. Our life skills camp will also provide exciting recreational community and therapeutic activities.

Please review the enclosed packet and the deadline dates. Please give detailed information regarding your campers’ needs. This will help provide a safe and fun-filled experience for all. All forms must be completed and submitted by **May 1, 2026**. These will be accepted on a first-come first-serve basis. Please send completed forms to: 224 N. Court St. Medina, Ohio 44256 Information concerning fees and financial aid for Medina County residents is included in the attached packet. We accept private pay; Family Resources; IO, Self-Waiver, and Level One Waiver; ESY (extended school year). Upon request, scholarships may be available based upon financial need and must be approved. Camp is \$400.00 per week (\$80.00 per day).

Checklist of items due May 1, 2026:

- *Complete Registration Packet
- *Parent/Guardian/Camper Consent form
- *Activities of Daily Living Form

Once your documentation is received, we will send confirmation to you with the date(s) your camper is registered to attend via email. If you need to cancel your camper’s registered week, please tell us as soon as possible. Please note, your \$100.00 reservation will be non-refundable, and is not applied to camp fees. We hope you join us for a new Life Skills experience.

We look forward to welcoming your child to Life steps Camp and fostering their summer growth and development.

Sincerely,

Kim Headrick
COO | Creative Living Lifestyles
kheadrick@cllifestyles.org
330-591-4434, ext. 7014



Registration Packet Due **May 1, 2026**

CAMPER REGISTRATION

Please mark an "X" on all weeks that your camper wishes to attend.

Camper's Name _____

- Explore the Parks of Medina County Week June 8-12**
- Art Appreciation Week June 15-19**
- Viva La France Week June 22-26**
- Lions, Tigers & Bears Week June 29 - July 2 (\$320 - 4 day week)**
- Sugar & Spice Week July 6-10**
- Acting/Improv Week July 13-17**
- Sports Week July 20-24**
- Water Adventures Week July 27-31**
- Fair & Festivals Week August 3-7**
- Rawhide Week August 10-14**

Amount of deposit \$ _____ **(\$100.00 non-refundable reservation required to reserve your dates. BALANCE must be paid 2 weeks PRIOR to week attending. Reservation is not applied to camp fees.**

Indicate form of payment:

Check enclosed Family Resources Waiver Private School

Family First Campership Request Morning Sun Scholarship

Other _____

Person, agency, or organization responsible for payment:

Agency: _____

Name: _____

Position: _____

Contact Phone: _____

Contact Email: _____

Fax: _____

Return registration forms with deposit to:
Creative Living Unlimited
(formerly Medina Creative Housing)
Life Steps
224 North Court St. Medina, Ohio 44256
330-591-4434



Registration Packet Due
May 1, 2026

EMERGENCY MEDICAL FORM (Page 1)

Camper Name: _____ <small style="display: flex; justify-content: space-around; width: 100%;">Last First M.I.</small>			Name / location of Preferred Hospital: _____		
Phone Number: _____		Individual own guardian: Yes No		Date of Birth: _____	
Current Address _____ <small style="display: flex; justify-content: space-between; width: 100%;">Street City State Zip Unit #</small>					
E-Mail: _____ Guardian Name & Email: _____					
Existing condition(s) for which medical interventions, special accommodation needed:					
Existing Condition			Intervention		
List of Medications					
Medication Name			Reason for Medication		
Dietary and Allergen Information					
Dietary Restrictions: <input type="radio"/> Yes, please list: _____ <input type="radio"/> No					
Individual's allergies (food, medication, environmental, insect stings, etc.) <input type="radio"/> Yes, see below: <input type="radio"/> No known allergies <input type="radio"/> Epi-Pen					
Allergen			Symptoms		

EMERGENCY MEDICAL FORM (Page 2)

Authorization for Emergency Medical Treatment

I give my permission to Medina Creative Accessibility to seek medical care if needed in case of injury or illness. I also give my permission to Medina Creative Accessibility to act on my behalf in the event of an emergency and to administer CPR/First Aid if needed.

Signature of Applicant: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

In Case of an Emergency Contact

PRIMARY

Name: _____
Last First

Phone No.: _____

Current Address _____
Street City State Zip Unit #

E-Mail: _____

2nd EMERGENCY CONTACT

Name: _____
Last First

Phone No.: _____

Current Address _____
Street City State Zip Unit #

E-Mail: _____

CAMPER INFORMATION

Camper's Name: _____
Last
First
M.I.

Brief Description of Camper's Disability/Special Needs

Does the Camper Have any of the Following? Copies MUST be provided

Individual Education Plan (IEP)	<input type="radio"/> Yes	Name of School District: _____
Behavioral Support Plan (BSP)	<input type="radio"/> Yes	Reason for Behavioral Support Plan: _____ _____
Individual Support Plan (ISP)	<input type="radio"/> Yes	Name of County the ISP is with: _____ Name of Service & Support Administrator: _____ _____
Seizure Plan	<input type="radio"/> Yes	Please include a copy of the Seizure Plan outlined and signed by the Camper's Physician with this application.
Require Communication Assistance	<input type="radio"/> Yes	Description of communication devices, programs, or strategies: _____ _____ _____

Explanation to Enhance this Camper's Experience

List Some Activities the Camper Enjoys, Additional Comments, or Suggestions

Behavioral Triggers / Strategies to De-Escalate

Camp Medical Record (page 1)

(This is a required form To Be Completed By Physician for all campers.)

If the camper is taking prescription medication an exam must be performed within 12 months of arrival at camp. We will also accept a copy of another examination signed by camper's doctor if within these time frames.

PHYSICIAN STATEMENT

Please Print Carefully:

Camper's Name _____

Date of Birth: _____ Age: _____

Please list **Allergies** if any: _____

Parent/Guardian: _____ Phone: _____

Name of Physician prescribing medication: _____

Contact Information: _____

TETANUS SHOT CURRENT (Within last 10 years): Yes _____ No _____

Medical Diagnosis: _____

Camper is to take Medications while at Life Steps (9:00 am – 2:00 pm):

Yes _____ No _____

(If YES, fill out page 2, Physician Order form for Medication Administration.)**

Please list all health concerns that staff should be aware of: _____

List any accommodations needed: _____

Dietary Restrictions: _____

Medical History: _____

I certify the above applicant is fit to participate in the Life Steps program and is free of communicable disease.

Physician Signature: _____ Date: _____

Physician Order Form for Medication Administration (page 2)

**(This is a required form To Be Completed By Physician For Medications That
Need Administered During Camp Hours 11:00 am – 4:00 pm)**

Individual's Name: _____ DOB: _____

Medications/Treatments:

Please indicate the reason(s) the individual is taking each medication. For PRN medications, please indicate parameters in which the medication should be given. Please include any OTC medications which should be administered on a scheduled/**PRN basis by delegated non-licensed staff.**

Name of Medication	Dosage and Frequency	Dispensing Method	Time of Med

Notes: _____

Physician's Signature: _____ Date: _____

**Physician orders are valid for one (1) year from the date of signature. Orders need to be attached to this document. Orders reviewed by MCA RN/Quality Assurance Staff _____
RN/Quality Assurance Staff will determine if appropriate for camp

Physician Order Form for As Needed Medication Administration

This Is A Required Form **To Be Completed By The Physician For:**

***** Medications That May Need Administered During the Life Steps Summer Camp Program
Hours 11:00 am – 4:00 pm*****

Individual's Name: _____ DOB: _____

Are there any Advanced Directives for this individual? Yes / No. If so, please attach.

Ordering Physician/Provider: _____

Physician Contact Number: _____

Allergies: _____

Dietary Restrictions: _____

Medical History: _____

Medications/Treatments:

- 1) **Acetaminophen 325 mg (Tylenol)** Give 650 mg (2 tabs) by mouth every 4 hours as needed for headache, pain or temperature of 100F or higher. Not to exceed 3250 mg (5 doses) in 24 hours.
- 2) **Ibuprofen 200 mg (Advil/Motrin).** Give 400 mg (2 tabs) by mouth every 4 hours as needed for headache, pain or temperature of 100F or higher. Not to exceed 3200 mg (8 doses) in 24 hours.
- 3) **Magnesium hydroxide 400mg/5mL (Milk of Magnesia).** Give 30 mL once by mouth as needed for constipation lasting longer than 24 hours.
- 4) **Colace Docusate Sodium 100mg** Give 100mg (1 capsule) by mouth for slight discomfort from constipation OR Give 200mg (2 capsules) by mouth for moderate to severe discomfort from constipation by mouth once a day.
- 5) **Aluminum hydroxide 200 mg, magnesium hydroxide 200 mg, simethicone 20 mg per 5 mL (Maalox)** Give 15 mL by mouth every 6 hours as needed for diarrhea or upset stomach. Do not exceed 4 doses in 24 hours. Discontinue use and contact physician for diarrhea lasting longer than 48 hours.

- 6) **Bismuth subsalicylate 525 mg/30 mL Susp. (Pepto-Bismol)** Give 30 mL by mouth every 1 hour as needed for diarrhea or upset stomach. Do not exceed 8 doses in 24 hours. Discontinue use and contact physician for diarrhea lasting longer than 48 hours.
- 7) **Loperamide hydrochloride 2 mg (Imodium)** Give 1 tablet by mouth as needed for diarrhea lasting longer than 12 hours. Not to exceed 3 doses in 24 hours. Discontinue use and contact physician for diarrhea lasting longer than 48 hours.
- 8) **Dextromethorphan hydrobromide 15mg/5mL (Robitussin)** Give 10 mL by mouth every six hours as needed for cough lasting longer than 12 hours.
- 9) **Benzocaine 15 mg / Menthol 2.6 mg lozenge (Cepacol Extra Strength)** Allow 1 lozenge to dissolve slowly in the mouth; may be repeated every 2 hours as needed for sore throat, sore mouth, minor mouth irritation, pain associated with canker sores. May use for up to 24 hours, if individual has no fever of 100F or higher.
- 10) **Pseudoephedrine 30mg (Sudafed)** Give 30 mg (1 tablet) by mouth every 4 hours as needed for nasal congestion. Not to exceed 240mg (8 doses) in a 24 hour period.
- 11) **Hydrogen Peroxide** May apply to minor cuts and abrasions as needed.
- 12) **Bacitracin 400 units, neomycin 3.5 mg, polymyxin B 5000 units (Triple antibiotic ointment)**
Clean the affected area with soap and warm water. Apply a small amount (equal to the surface area of the tip of a finger) to the area up to 3 times daily as needed for small cuts, scrapes, and minor burns without a blister.
- 13) **Americaine Benzocaine Topical Antiseptic Spray** Apply to affected areas for temporarily relief of pain and itching associated with: minor cuts, scrapes, minor burns (sun burns), insect bites
- 14) **Sun Protection (sunscreen) SPF #30 or greater.** Apply to skin that may be exposed to the sun every hour as needed to protect from a sun burn.
- 15) **Moisturizing Lotion.** Apply to skin or lips as needed for dry skin.

Physician's Signature: _____ Date: _____

Physician orders are valid for one (1) year from the date of signature. *

MCA Staff: _____ Date: _____

Orders reviewed by MCA RN/Quality Assurance

Legal Guardian/Parent(s): _____ Date: _____



Registration Packet Due
May 1, 2026

LIFE STEPS Consent Form

Camper's Name: _____

Yes No I authorize Life Steps staff to act for me
in a responsible manner in case of an emergency
that requires medical care.

Yes No I authorize the Camp staff to administer the campers
prescription and/or over the counter PRN medications as listed
on their medical form and ordered by their physician.

Yes No I give permission for Life Steps staff to transport camper
for outings and activities.

Yes No I give MCA permission to photograph or video tape
Camper while they are engaged in activities.
I also give permission for the public
dissemination of this material for education and
promotional purposes.

I authorize the following individuals listed to pick up my camper.

Parent or Legal Guardian Signature _____

Date: _____

Please provide a copy of the Legal Guardianship documents.

ACTIVITIES OF DAILY LIVING FORM

CAMPER'S NAME: _____ DATE _____

Please be as specific as possible:

<p>EATING/DRINKING:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Needs food cut up and special plate or utensil (list: _____)</p> <p><input type="checkbox"/> Must be fed</p> <p><input type="checkbox"/> Can use straw</p> <p>Explain: _____</p> <p>_____</p>	<p>DIET:</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Low salt</p> <p><input type="checkbox"/> Low calorie – Total calories (_____)</p> <p><input type="checkbox"/> Diabetic – Total calories (_____)</p> <p><input type="checkbox"/> Knows limits</p> <p><input type="checkbox"/> Chopped food <input type="checkbox"/> Blended/pureed food</p> <p>List food restrictions: _____</p> <p>_____</p> <p>List food allergies: _____</p> <p>_____</p>
<p>MOBILITY:</p> <p><input type="checkbox"/> Walks independently</p> <p><input type="checkbox"/> Walks: Needs assist w/ slopes, rough areas</p> <p><input type="checkbox"/> Wheelchair: Independent</p> <p><input type="checkbox"/> Wheelchair: Assist w/ slopes, rough areas</p> <p><input type="checkbox"/> Wheelchair: Needs assist at all times</p> <p><input type="checkbox"/> Wheelchair: Long distances only</p> <p><input type="checkbox"/> Requires rest during the day</p>	<p>TRANSFERS:</p> <p>Camper weighs: _____ lbs.</p> <p><input type="checkbox"/> Can make independently</p> <p><input type="checkbox"/> Pivot transfers/can bear weight on feet</p> <p><input type="checkbox"/> Must be lifted *</p> <p>Please explain: _____</p> <p>_____</p> <p>* must provide own Hoyer, if needed.</p>
<p>DRESSES/UNDRESSES:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Needs partial assistance</p> <p><input type="checkbox"/> Needs total assistance</p> <p>Explain: _____</p> <p>_____</p> <p>_____</p>	<p>ADAPTIVE EQUIPMENT:</p> <p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Contacts</p> <p><input type="checkbox"/> Hearing Aid</p> <p><input type="checkbox"/> Dentures</p> <p><input type="checkbox"/> Other (list) _____</p> <p>_____</p>
<p>BATHROOM:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Bladder incontinence</p> <p><input type="checkbox"/> Bowel incontinence</p> <p><input type="checkbox"/> Requires prompting for toileting</p> <p><input type="checkbox"/> Needs transfer to toilet</p> <p><input type="checkbox"/> Needs assistance wiping</p> <p><input type="checkbox"/> Needs total assistance</p> <p><input type="checkbox"/> Uses toilet chair</p> <p><input type="checkbox"/> Uses special undergarments</p>	<p>SWIMMING:</p> <p><input type="checkbox"/> Requires Life Jacket or Floatation Device</p> <p>SUPERVISION LEVEL:</p> <p><input type="checkbox"/> Independent <input type="checkbox"/> Auditory <input type="checkbox"/> Visual</p>

Parent or Legal Guardian Signature _____

Date: _____



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May 1, 2026

LIFE STEPS CAMPERSHIP APPLICATION

Assistance may be available for those unable to attend for financial reasons. Please indicate the amount you are able to pay in the space provided below. Partial payment allows us to grant camperships to more individuals. To apply for this assistance, please fill in the following information and a representative will contact you.

(Please Circle) Camper will attend: Week 1 2 3 4 5 6 7 8 9 10

Please indicate amount you are able to pay towards camp fee: \$ _____

Waiver funding: Yes _____ No _____

Family Resources: Yes _____ No _____

Private: Yes _____ No _____

Scholarship: Yes _____ No _____

If yes, the amount applied toward Life Steps Camp: \$ _____

Camper's Name:

Address: _____

Phone: _____

Email: _____

Please show verification of fiscal need and a brief explanation of need:



Registration Packet Due
May 1, 2026

LIFE STEPS FINANCIAL RESPONSIBILITY FORM

I fully understand that if a funding source fails to pay for the cost of Life Steps Camp, I will be held responsible for any and all unpaid balances. I understand that I need to pay a \$100.00 reservation per week that is non-refundable if my child does not attend a registered camp week, and is also not applied to camp fees.

Signature

Date

Legal Guardian Signature

Date