

2012 New Avenues Broadmoor Summer Camp

CAMP DATES: JUNE 25-JULY 27 (5 weeks)

Note: **PLEASE SUBMIT AN APPLICATION NOW TO HOLD A SPOT** even if you are waiting for a meeting with your school district, (keep the medication page for Dr. signature, if needed). Applications may be dropped off at Broadmoor School or mailed to: Gretchen Halliday, Program Director, New Avenues to Independence, 17608 Euclid Ave., Cleveland, Ohio 44112-1216

PLEASE INCLUDE A COPY OF THE IEP WITH THIS APPLICATION to help us plan for your child's needs.

CHILD'S NAME: _____ **AGE:** _____ **DOB:** _____

PARENT(S)/GUARDIAN(S) NAME(S): _____

ADDRESS: _____ **City:** _____ **ZipCode:** _____

E-Mail 1: _____ **Day Phone 1:** _____ **Cell 1:** _____

E-Mail 2: _____ **Day Phone 2:** _____ **Cell 2:** _____

Child's Address (if different than parent's): _____

Camper T-shirt: Child: S M L Adult: S M L XL XXL

CHILD'S SCHOOL DISTRICT:

- Fairport Harbor Painesville City Kirtland Riverside Willoughby-Eastlake
 Madison Wickliffe Perry Mentor Other: _____

SUPPLEMENTAL THERAPIES

My child will need weekly therapy: ___OT ___SPEECH ___PT **All therapies are \$43 per session.**
___ I will be paying the additional cost of therapy. ___ I will be asking my school district to pay for therapy.

FAVORITE ACTIVITIES:

FINE MOTOR (involving hands):

___ Arts & Crafts ___ Drawing ___ Painting ___ Puzzles ___ Board Games ___ Computer Games ___ Cars, Trucks ___ Dolls ___ Blocks

OTHER LIKES: _____ DISLIKES: _____

SENSORY (touching, sounds, visual)

___ Play Doh ___ Shaving Cream ___ Music ___ Weighted activities ___ Vibration ___ Singing Favorite Books: _____

___ Uses one point vestibular swing ___ Uses weighted vest ___ Uses chewy ___ Uses vibrating toy

OTHER LIKES: _____ DISLIKES: _____

LARGE MOTOR (whole body):

___ Taking Walks ___ Running ___ Outdoor play ___ Swinging ___ Dancing ___ Balls ___ Bike riding ___ Trampoline

Activities to be **encouraged:** _____

Activities to be **restricted:** _____

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HEALTH INFORMATION

Autism /PDD Down Syndrome Cerebral palsy Developmental Delay / Other: _____

ALLERGIES: _____

Past surgeries, medical issues we should know about: _____

Current medical issues: _____

SEIZURES? no yes: Number of seizures per month: Date of last seizure: Usual length:

VISION problems? no yes Describe: _____

HEARING problems? no yes Describe: _____ Uses hearing aid: yes no

WALKING: no problems unsteady, needs some help uses wheelchair uses walker

COMMUNICATION: average for child's age delayed reads words

 Uses **icons** (pictures) knows some **sign language** Uses **sounds, gestures** Uses **a device**

EATING: Independent Needs some help Needs total assistance: _____

 History of choking or swallow problem Special instructions/utensils/foods/diets: _____

DRESSING: Independent Needs some help Needs total assistance

TOILET: Independent Needs some help Needs total assistance Wears **diapers/ briefs**

Instructions/Toileting program: _____

How does your child let others know he needs to go? _____

SAFETY / BEHAVIOR:

What to do when your child is getting upset (describe): _____

Rewards/ reinforcers: _____

Words to help your child feel good or help them through situations: _____

SENSORY LIKES/ DISLIKES: _____

Does not like to touch certain textures, foods, sounds: _____

Behavior concerns:

- Leaves room without asking/telling
- Bites/scratches self or others
- Crying/screaming at times for unknown reasons
- Withdraws from group activities
- Difficulty transitioning from one activity to another
- Temper tantrums
- Other concerns (describe):

- Aggressive toward others, throws things
- Hits/slaps self or others
- Spits
- Climbs on tables, etc.
- Takes off clothing inappropriately
- Self-stimulating sexual behavior

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WATER ACTIVITY (SWIMMING) AUTHORIZATION FORM

CHILD'S NAME _____

The above named child has my permission, as the parent or legal guardian of said person, to participate in all planned and supervised Aquatics Activities provided by the Broadmoor Summer Camp.

_____ YES, My child can participate _____ NO, My child cannot participate

SPECIAL INSTRUCTIONS OR EQUIPMENT (Wings, Floats, etc) FOR SWIMMING:

_____ **My child knows how to swim, does not usually wear a floatation device**

Signature of Parent/Guardian

Date

PHOTO AUTHORIZATION

May Staff take pictures of your child to be used **within** Summer Camp to identify personal space, use in crafts, etc?

_____ YES _____ NO

May New Avenues use your child's photo in still or video pictures for use within and outside of Summer Camp for educational, promotional, or other appropriate purposes, **NOT INCLUDING THE WEBSITE?**

_____ YES _____ NO

May New Avenues use your child's photo in still or video pictures for use outside of Summer Camp for educational, promotional or other appropriate purposes on **NEW AVENUES' WEBSITE, www.newavenues.net?**

_____ YES _____ NO

May New Avenues use your child's photo in still or video pictures for use outside of Summer Camp for educational, promotional or other appropriate purpose on **NEW AVENUES' FACEBOOK PAGE?** (Please note that this is NOT for permission to use any pictures on personal pages of staff or volunteers).

_____ YES _____ NO

Signature of Parent/Guardian

Date

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION

To enable parents and guardians to authorize emergency treatment for students who become ill or injured while under the authority of the New Avenues Broadmoor Summer Camp, and/or when parents or guardians cannot be reached.

Child's Name: _____ DOB: _____

CONTACTS IN CASE OF EMERGENCY (Other than Parents/Guardians):

Parents listed on first page will always be contacted first.

Name: _____ Phone: _____
(Relationship to child)

Name: _____ Phone: _____
(Relationship to child)

PART I – CONSENT

In the event reasonable attempts to contact me or other parent or designee have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment necessary by a licensed physician or dentist; and/or
2. The transfer of my child to _____ (preferred hospital) or any hospital reasonably accessible.
3. My family physician is _____ (full name), at _____ (phone).
4. My family dentist is _____ (full name), at _____ (phone).
5. I understand that if he/she is not available another physician / dentist will be contacted.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent / Guardian

Date

PART II – REFUSAL TO CONSENT

(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish staff of the Broadmoor Summer Camp to:

(please specify) _____

Signature of Parent / Guardian

Date

PART III- INSURANCE INFORMATION:

Name of insurance company: _____

Insurance Numbers (group no., individual no.) _____

CONSENT FOR SCHOOL RECORDS RELEASE

PLEASE SIGN EVEN IF YOUR CHILD ATTENDS BROADMOOR SCHOOL!

The following form should be filled out for ALL children. The purpose of this release of information form is to give permission for your child's regular school to release a copy of the current IEP to the Broadmoor Summer Camp or pertinent information from the teacher. Although your child's IEP is not valid during the summer months, staff at Broadmoor Summer Camp will use the IEP information to become familiar with your child's ability level and to reinforce goals as much as possible. Thank you for your cooperation!

SCHOOL NAME:	Child's Name:
TEACHER'S NAME:	Child's DOB:
(School Address)	
(City, State, Zip Code)	

I am requesting the following information / records for the above-named student be released to New Avenues:

THERAPY EVALS

- CURRENT IEP and ESY GOALS (if applicable) to focus on during summer camp**
 - BEHAVIOR PLAN AND GUIDELINES (if applicable)**
 - TEACHER INFORMATION(form included)**
-

Please release information to:
GRETCHEN HALLIDAY

NEW AVENUES TO INDEPENDENCE, INC.
BROADMOOR SUMMER PROGRAM
8090 BROADMOOR AVE.
MENTOR, OHIO 44060

Date

Signature of parent/guardian

**AUTHORIZATION TO ADMINISTER MEDICATIONS
AND CURRENT MEDICATION LISTING**

A complete list of current medications is a necessity should there be an emergency medical situation or drug reaction. **Please complete list of medications on page 7 of this application. This is needed for ALL campers.**

The medication list must include not only medications prescribed by a physician but also those the child's parents/guardians may purchase over-the-counter. This list should additionally include any medications the student takes occasionally even though they may not be part of a daily medication routine.

The nurse is permitted to administer medication only in accordance with the following procedures (THIS IS STATE LAW):

1. The name, dosage and frequency of the medication to be administered and the name of the doctor that prescribed the medication and the date it was prescribed must be on the pharmacy labeled container.
2. For prescription drugs, the parent/guardian or responsible party must deliver a supply of medication to the nurse in a pharmacy labeled container. **CHILDREN ARE NOT PERMITTED TO TRANSPORT MEDICATIONS, EVEN IN A LUNCHBOX OR BOOKBAG!!**
3. For non-prescription drugs, the parent/guardian or responsible party must deliver a supply of the medication in the original manufacturer's container. The container should be labeled with the dosage and frequency that the drug is to be administered.
4. The nursing staff has the right and responsibility to check with the physician regarding the administration of any medication when in their best judgment it is prudent to do so.
5. The nurse can dispense no medication other than those listed below.
6. The person who signs this authorization is responsible to notify the nurse of any medication changed including dosage levels and times of administration.

Please check one:

- _____ () Will be taking medication during Summer
Child's Name Camp
() Will **NOT** be taking medication during
Summer Camp

REQUEST / CONSENT FOR ADMINISTRATION OF MEDICATION

(Must complete if medicine is to be administered during camp)

***** PHYSICIAN AND PARENT/GUARDIAN MUST SIGN THIS FORM *****

Keep this form until Dr. signs it and give to nurse by June 22 or FAX TO: 440-602-1003, ATTN. GRETCHEN H.

CHILD'S NAME: _____

MEDICATION:	
DOSE:	TIME GIVEN:
HOW GIVEN:	
PURPOSE:	SIDE EFFECTS:

MEDICATION:	
DOSE:	TIME GIVEN:
HOW GIVEN:	
PURPOSE:	SIDE EFFECTS:

MEDICATION:	
DOSE:	TIME GIVEN:
HOW GIVEN:	
PURPOSE:	SIDE EFFECTS:

G-TUBE FEEDING:	
TYPE:	TIME GIVEN:
AMOUNT:	
SPECIAL INSTRUCTIONS/PRECAUTIONS:	

ONLY-AS-NEEDED MEDICATIONS: (including Tylenol, etc.)	
TYPE:	TIME GIVEN:
AMOUNT:	
SPECIAL INSTRUCTIONS/PRECAUTIONS:	

I request and give permission for my child to receive the above medications at summer camp.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

FINANCIAL INFORMATION

Families with an outstanding balance from previous years cannot enroll until all payments have been made.

Tuition fees for the 5 weeks of camp are \$975 for Lake County residents. Cost is \$1150 for out-of-county residents.
Therapy services are available for an additional charge: OT, Speech, PT,: **\$43 per 1/2 hr.**

Tuition is due by June 22, 2012

Please complete and return the accompanying Payment Transmittal Form

THERAPY SERVICES REQUESTED: ___ SPEECH ___ OT ___ PT

Frequency of Therapy (\$40per session): ___ once weekly (total \$200) ___ twice weekly (total \$400)

Responsible party for payment: ___ family ___ school district: _____ (name of district)
___ other: _____

PAYMENT TRANSMITTAL

Name of Participant _____

Payment Method

Check - Payable to: *New Avenues to Independence* Amount \$ _____
(Be sure **to note the name of the child** on your check)

Credit Card: ___ MasterCard or ___ Visa Amount \$ _____

Account No. _____

Name on Card _____

Exp. Date ___/___/___

FRS: _____ Amount \$ _____

Explanation

ESY: _____ Amount \$ _____

Explanation

Other: _____ Amount \$ _____

Explanation

NOTE: If payment is guaranteed by a 3rd party provider, attach a copy of their authorization or certification.

Please return your Transmittal with payment to:

Attn: GRETCHEN HALLIDAY
New Avenues to Independence
17608 Euclid Avenue
Cleveland, Ohio 44112