

Camp Hope 2010 Tuition Fees

Fees for camp will be based on the camper's age and staff ratio provided to them. This fee includes transportation and lunch, but does not include the fee for one-to-one services or the extended school year program.

Age of Camper	Staff Ratio	Fee per week
5- 12 years old	1 staff : 3 campers	\$490.00 per week
13 - 20 years old	1 staff : 5 campers	\$400.00 per week
21 years old and over (The ACE Program)	1 staff : 6 campers	\$450.00 per week

(If your camper will be changing age groups close to the start of camp or during camp, it will be up to the camp administration to decide what age group they will be placed in.)

Adult Camping Experience Program (ACE):

This program is for our adult campers 21 years and older. They will be provided with a 1 staff to 6 camper ratio and will go out into the community 1 time per week for trips and activities. These trips may include the movies, the park, bowling, or miniature golf. The higher cost will cover admissions for all these activities as well as the additional transportation expenses.

Extended School Year Program:

If your child is attending Camp Hope's extended school year program, an additional **\$125.00 per week** will be added to the school district's bill for that program to be included in the camp day.

One-to-One Fees:

All campers will be charged a flat rate of **\$750.00 per week** if they are in need of their own one-to-one aide that Camp Hope will provide

Transportation Discount:

For families who do not utilize our transportation a discount of \$100.00 per week of attendance will be credited.

A copy of your bill will be sent upon application review. Please review this bill carefully. If you have any questions regarding fees, please call (973) 535-1181 ext. 1264.

CAMP HOPE APPLICATION FORM-2010
CONTACT INFORMATION FORM

Camper Name: _____ Nickname: _____

Sex: _____ Date of Birth: _____ Height: _____ Eye Color: _____

Child's Classification/Disability: _____ Hair Color: _____

Emergency Contact Information other than names of mother/father/guardian listed on first page.

MUST PROVIDE 2 NAMES AND NUMBERS

1. Emergency Contact Name: _____

Relationship to camper: _____

Emergency Contact Home Phone #: _____

Work #: _____

Cell or Pager #'s: _____

2. Emergency Contact Name: _____

Relationship to camper: _____

Emergency Contact Home Phone #: _____

Work #: _____

Cell or Pager #'s: _____

Camper's School Name or Work Place: _____

Camper's School Name or Work Place Phone #: _____

Camper's Teacher or Supervisor's Name: _____

(Over, please)

Camp Hope Release 2010

- A. Pictures of camper and camper activities may be taken and used for publicity purposes including but not limited to publications in commercial periodicals, camp newsletters, The ARC of Essex internet site and various publications of The ARC of Essex County. _____ **Initials of parent or guardian.**
- B. Camp Hope and The ARC of Essex reserve the right to release any camper from the camp program if, after a trial period, the ARC feels that it is not in his /her best interest to remain in the program. _____ **Initials of parent or guardian.**
- C. **RELEASE:** I hereby release The ARC of Essex County, Camp Hope, and its employees of any responsibility or liability for any injury and/or illness derived from participation in the Camp Hope Program. I acknowledge the conditions set forth above and agree with their contents in their entirety. _____ **Initials of parent or guardian.**
- D. I hereby give permission for my camper to participate in any off site field trips which are part of the day camping program. _____ **Initials of parent or guardian.**
- E. I, hereby give The ARC of Essex County, Inc. (“The ARC”) the Camp Hope (“Camp”) administration, and the medical personnel selected by the Camp Director (or his/her designee) permission to order X-rays, routine medical tests, and medical treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child, the below identified camper.

I understand that the Camp will make reasonable attempts to communicate with me prior to medical treatment in non-life threatening and other non-emergency situations, but that in accordance with the preceding paragraph, medical examination and treatment will be performed without necessarily communicating with me first or in life threatening and other emergency situations, even without attempting such communication. I give consent for transportation to a medical facility (by ambulance or school vehicle) in the event of an emergency.

I understand that the permission I have given by signing this form is a material inducement to acceptance of my child as a camper. I also confirm that I have given the Camp and The ARC a complete and accurate medical history of my child. _____ **Initials of parent or guardian.**

Signature of parent / guardian

Date

Camp Hope Transportation Release Form-2010
Form to be given to the bus company

I, _____, hereby give The ARC of Essex County, Inc (“The ARC”) the Camp Hope (“Camp”) administration, and the medical personnel selected by the Camp Manager (or his/her designee) permission to order X-rays, routine medical tests, and medical treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child, the below identified camper.

I understand that the Camp will make reasonable attempts to communicate with me prior to medical treatment in non-life threatening and other non-emergency situations, but that in accordance with the preceding paragraph, medical examination and treatment will be performed without necessarily communicating with me first or in life threatening and other emergency situations, even without attempting such communication. I give consent for emergency transportation to a medical facility (by ambulance or school vehicle) for my child.

I understand that the permission I have given by signing this form is a material inducement to acceptance of my child as a camper. I also confirm that I have given the Camp and The ARC a complete and accurate medical history of my child.

Camper’s name: _____

Signed: _____ Date: _____
(Signature of parent / guardian)

Witness: _____ Date: _____
(Signature of witness)

The following information will help us to determine your camper’s bus stop and pick-up / drop off times. Address must be in Essex County.

Camper’s Name: _____

Pick-Up and Drop off Address: Number, Street & City _____
(must be the same) _____

Phone # at pick up: _____ Phone # at drop off: _____

Emergency Information

Name: _____ Relationship: _____
Address: _____ Phone #: _____
City & Zip _____

Camp Hope Camper Information-2010

Camper's Name: _____

Camper's Age: _____ Date of Birth: _____

Please answer the following questions pertaining to your child's strengths and areas in need of development. This information will be used by the Camp Manager and the staff to develop program activities that will be appropriate for your family member. It will also assist in making his / her experience as comfortable as possible. Your honest assessment will be most helpful since you know your family member better than anyone.

Supports Needed

Does your child have special needs such as toilet assistance, a behavior plan, dressing or feeding assistance, etc? If yes, please explain:

Verbal Expression

How does participant communicate? (ex: sign language words, gestures) How does he/she make needs known to others?

Non-Verbal Expression

Describe how participant makes need known to others:

Physical Condition/Mobility

Describe general mobility, coordination and conditions in which participant may need assistance:

School Environment

What is the class ratio (how many teachers and how many students) in your campers classroom setting?

(Over, please)

Social/Emotional Development

Describe participant's ability to relate to peers and adults, including reactions to authority (ex. tantrums passive/withdrawn, crying, property destruction, physical aggression yelling, name calling):

Describe degree of aggression, if any, towards self, others, or property:

Describe what motivates your camper, or strategies which are successful in working with your child. If a behavior plan is used, please describe in detail.

Describe any fears of which staff should be aware (ex: dogs, loud noises, rain, bugs, crowds, heights, stairs, etc.):

Describe participant's favorite activities, person, fictional character, toys, etc.:

Describe other activities in which participant have been involved outside of home (Ex. School, Work, Special Olympics, Vacations, Camps, etc.)

Does participant wear/use:

Eye glasses _____ Hearing Aid _____ Ear Plugs _____

Orthodontic braces/retainer _____ Orthopedic Braces _____

Wheelchair _____ Walker _____

Communication board (must accompany child to program) _____

Describe your child's swimming abilities. (Ie. loves to swim, experienced or non experienced swimmer, fear of water, does not like to swim, can swim in water over his/her head.)

Additional comments/suggestions/your goals for your camper this summer:

CAMP HOPE TEACHER INFORMATION-2010

MUST BE FILLED OUT BY TEACHER

CAMPER: _____

Dear Teacher,

The individual whose name appears above will be attending Camp Hope this summer. Camp Hope is a specialized day camp serving individuals ages 5-21. In order to develop an appropriate program for this individual, we feel your input is imperative. Although the primary goal of our program is recreational, many of our staff understands the importance of maintaining skills and achieving goals, even though school is not in session. If you are interested in contacting the staff, please feel free to call us at (973) 535-1181, ext. 1264. Thank you in advance for your cooperation and completion of this form.

Parent signature authorizing release of information: _____

Teacher's Name: _____

Name of School: _____ School Phone #: _____

Type of Class: _____

Child's Disability: _____

Classroom Ratio: _____

Please describe performance in the following areas:

- * Can the student perform the following classroom skills?
Read _____ If yes, at what level _____
Write his /her name _____
Write words _____
Write sentences _____

- * What classroom activities does this student like?
The Most _____
The Least _____

(Over, please)

CAMP HOPE TEACHER INFORMATION PAGE 2

2010

* **Favorites**
 Books _____
 Songs _____
 Movies _____
 Television shows _____
 Hobbies _____
 Other _____

* **Social Interactions**
 Peers _____
 Adults _____
 Authority _____
 Out of school environment (ex: field trips, recess, etc.) _____

* **Behavioral Challenges** (please include triggers)
 Aggression towards self _____
 Aggression towards others _____
 Self-simulatory _____
 Verbal aggression _____
 Property destruction _____
 Is this child on a behavior plan? If so, please describe in detail.

 Other _____

* **Strategies/Techniques**
 Motivating _____
 Increasing desired behavior _____
 Decreasing inappropriate behaviors _____

* **Summer Goals** _____

* Please use additional paper if necessary

* **Is there a number to reach you at during the summer to discuss this camper if needed?**
 Phone Number: _____

Please Return to:

**Camp Hope / ARC of Essex County
 123 Nylon Ave.
 Livingston, NJ 07039**

School District Response Form 2010

Form is to be completed by school district upon decision to use The ARC of Essex County's Summer Day Program at Camp Hope for extended school year program.

From: _____ (Authorized district personnel)

_____ (School District)

_____ **Contact Person**

_____ **Phone Number**

Re: _____ (Child's Name)

This is to confirm that the parent of _____ have requested this district for an extended school year program. The district has agreed to provide extended school year programming at The ARC of Essex County's Summer Day Program at Camp Hope.

Signature

Date

Printed Name

Title

Phone Number

District Mailing Address

First Time Camper Visit Sign Up Sheet 2010

Camper's Name _____

Phone # _____

This visit is mandatory for any camper that has never attended Camp Hope previously.

Upon application review, your appointment will be confirmed by the Camp Hope Staff.

Date (please Circle one)	Location	Time (please circle one)
MARCH 22 nd MON	LIVINGSTON	3:30 4:00 4:30 5:00 5:30
APRIL 14TH WED	LIVINGSTON	3:30 4:00 4:30 5:00 5:30
APRIL 24TH SAT	BLOOMFIELD	9:30 10:00 10:30 11:00 11:30 12:00
MAY 11TH TUE	LIVINGSTON	3:30 4:00 4:30 5:00 5:30
MAY 20TH THUR	BLOOMFIELD	3:30 4:00 4:30 5:00 5:30
MAY 26TH WED	LIVINGSTON	3:30 4:00 4:30 5:00 5:30

If these dates and times do not work for you or you are registering after the last interview date, please call (973) 535-1181 ext. 1264 to make other arrangements.

Livingston Address: 123 Naylor Place, Livingston, NJ

Bloomfield Address: 1285 Broad Street, Bloomfield, NJ

The Arc of Essex County
123 Naylor Avenue, Livingston, New Jersey 07039

Financial Aid Information Form

PLEASE PRINT

Child's Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian Name: _____ Age: _____

Address: _____

Telephone Number: _____

Occupation: _____ Employer: _____

Address of Employer: _____

Parent/Guardian estimated gross income for 2009: \$ _____

Parent/Guardian Name: _____ Age: _____

Address: _____

Telephone Number: _____

Occupation: _____ Employer: _____

Address of Employer: _____

Parent/Guardian estimated gross income for 2009: \$ _____

OTHER INCOME (Such as Supplemental Security Income (SSI), Social Security Disability, etc.):

(Please complete other side)

Please list all dependents living in the home (brother, sisters, other relatives)

	NAME	AGE	RELATIONSHIP	OCCUPATION
1				
2				
3				
4				
5				
6				
7				
8				

Other or unusual expenses contributing to financial need: _____

Date: _____ Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Please attach your 2009 tax return with this application to be considered for assistance.

FOR OFFICE USE ONLY

Program: _____ Maximum fee per month: \$ _____

Action taken: _____ Reviewer: _____

Fee arrangement: \$ _____ per month

Date to begin: ____/____/____

Note:

2010
Payment Sheet

If you are paying for Camp with a credit card, please fill out below:

_____ Visa _____ MasterCard

Credit Card Authorization #: _____

Expiration Date: _____

Name on Credit Card: _____

Camper's Name: _____

Billing Address: _____

Amount \$ _____

Authorized Signature X _____

FOR OFFICE USE ONLY

Check Number _____ Amount _____

Money Order Number _____ Amount _____

Camp Hope Health History and Examination Form-2010

Pages 1 and 2 are for parent/guardian to complete and sign.

Pages 3 and 4 are for physician to complete and sign.

Name of Camper: _____

Address: _____ City: _____ Zip: _____

Name of Physician _____

Address: _____

City & Zip: _____

Phone #: _____

ALLERGIES

List all known

Medication Allergies	Describe reaction and management of the reaction
----------------------	--

Food Allergies	
----------------	--

Other Allergies – Include plant, animal, insect, asthma, etc.

Restrictions – List all that apply

Dietary _____ Activities _____

(Over, please)

General Health Questions – 2010

Please explain any yes answer on the spaces provided.

DOES YOUR CAMPER HAVE:

	<u>Current</u>	<u>History of Problem</u>
A) Asthma	_____	_____
B) Diabetes	_____	_____
C) Frequent Colds	_____	_____
D) Pneumonia	_____	_____
E) Lung / Breathing Problems	_____	_____
F) Seasonal Allergies / Other	_____	_____
G) Ear Infections	_____	_____
H) Frequent Headaches	_____	_____
I) Serious Skin Problems	_____	_____
J) Gum Problems	_____	_____
K) Dental Problems	_____	_____
L) Hypertension	_____	_____
M) Heart / Circulatory Problems	_____	_____
N) Stomach / Digestive Problems	_____	_____
O) Kidney / Urinary Problems	_____	_____
P) Pica (eats inedible objects)	_____	_____
Q) Hepatitis B Carrier	_____	_____
R) Seizure Disorder***	_____	_____

*** Please complete the enclosed seizure form to provide us with details regarding your child's seizure disorder.

To my knowledge this Health History Form is complete and accurate. The person herein described has permission to engage in all Camp activities except as noted.

Signature of parent / guardian

Date

THE ARC OF ESSEX COUNTY'S CAMP HOPE PROGRAM

PHYSICIAN'S EXAMINATION Form -2010
(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

Name of Patient: _____

I have examined the individual named on this form.

Date of last OK examination: _____

Height _____	Ears _____	Heart _____	Skin _____
Weight _____	Nose _____	Lungs _____	Scalp _____
Pulse _____	Throat _____	Abdom. _____	Spine _____
BP _____	Eyes _____	Hernia _____	Extm. _____

In my opinion this individual ____ is ____ is not able to participate in all camping activities. They may NOT participate in the following activities:

The individual is under the care of a physician for the following reason:

Diagnosis(s): _____

MEDICATIONS:

____ This individual takes NO prescribed medications on a routine basis.

____ The following medications are ordered for the person named on this form. (If a person is on ANY medications that will be administered during camp, even Ibuprofen, a prescription must accompany medications. The prescription must specify hour of day for administration (ex. 12:00 PM not lunchtime). The prescription must also give specific instructions for administration (ex. Grind pill, open capsule, take with food, etc.)

(Over, please)

Medication*	Administration Times / Special Instructions
Med # 1 _____	_____
Med # 2 _____	_____
Med # 3 _____	_____
Med # 4 _____	_____

*if there are additional medications, please attach a separate piece of paper

Medically prescribed diet: _____

Treatment (s) administered at camp: _____

Known Allergies: _____

IMMUNIZATION RECORD (EITHER FILL THIS SECTION OUT OR SEND, A CHART COPY/PRINTOUT)

	Date	
MENINGITIS	_____	
VACCINE	_____	
DTP	_____	
TD (TETANUS/ DIPHTHERIA)	_____	
TETANUS	_____	
POLIO	_____	
MEASLES	_____	
MUMPS	_____	
RUBELLA	_____	
HAEMOPHILUS B	_____	
CHICKEN POX	_____	
HEPATITIS	_____	
YB MONTEUX*	_____	results _____
PNEUMOCOCCAL	_____	

Additional Information for health care staff at camp:

Signature of physician: _____ **Date:** _____

Name of physician (please print) _____

Address _____

Phone # _____

**The ARC of Essex County
Seizure Information Form**

Name of Camper: _____

In an effort to support your son/daughter with the proper supports while they are in our services, please fill out the following information completely. This is to enable us to understand what a TYPICAL seizure looks like in relation to your son/daughter. If your son/daughter does NOT have a seizure disorder, please sign below. Thank you.

My son/daughter does not have a seizure disorder as of this date.

Parent/Guardian Signature

Date

If the Camper has a seizure disorder, please complete and sign below.

History:

Events or behaviors just before a seizure begins: _____

Time of day seizure typically occurs: _____

Triggers: _____

Seizure Classification: _____

When was the last seizure? _____

Description:

Lost consciousness _____

Falling _____

Noises _____

Irregular Breathing _____

(OVER)

Movements:

Head and Face: Nodding ____ Jerking ____ Twitching ____

Mouth: Sucking ____ Chewing ____ Lip Smacking ____ Grimacing ____

Eyes: Staring ____ Blinking ____ Rhythmic Movement ____

How long does each seizure in a series last? _____

Other Symptoms:

Drooling ____ Tongue Biting ____ Dilated Pupils ____ Urination/ Soiling ____

Frothing ____ Sweating ____ Flushed ____ Vomiting ____ Pale ____

Goose pimples ____

Typical seizure lasts ____ minutes.

Does he/she usually have more than one seizure at a time? Yes ____ No ____

If yes, how many in a row? _____

How long does each seizure in a series last? _____

Post Seizure Behavior:

Normal ____ Restless ____ Sleepy ____ Confused ____ Deep sleep ____

Irritable ____ Other: _____

On the lines located below, please include any other information that may not have been included on the above checklist or to elaborate on any area:

This seizure history is complete and correct as far as I know.

Signature of Parent/Legal Guardian Date

AUTHORIZATION TO APPLY SUNSCREEN

I, _____ authorize The ARC of Essex County's
(name of parent or guardian)

Children, Family & Community Services/Camp Hope Staff to administer to

_____ the following sunscreen as instructed below.
(camper's name)

TYPE OF SUNSCREEN	ADMINISTRATION TIME	PHYSICIAN'S INSTRUCTIONS (if ANY)
1.	AFTER DAILY SWIM TIME	
2.	AFTER DAILY SWIM TIME	

This authorization covers the period in which the Camp Hope staff is providing care to my son/daughter.

Signature of parent/guardian

Date

THE ARC of ESSEX COUNTY
Authorization for Disclosure of Health Information

Individual's Name: _____ Date of Birth: _____

I understand that the above named individual is using the services provided by the ARC of Essex County and the ARC of Essex County may require information from other agencies, providers, or individuals in order to provide services. I also consent for the ARC of Essex County and the following designated agencies or individuals to disclose and communicate to one another information and records in their possession which relate to services and or treatment provided for the above named individual:

Name: Division of Developmental Disabilities (DDD)
 Address: 153 Halsey Street, 2nd Floor
Newark, NJ 07101
 Phone: (973) 693-5080

Name: _____
 Address: _____

 Phone: _____

Name: M & VALLEY TRANSPORTATION
 Address: _____

 Phone: _____

Name: _____
 Address: _____

 Phone: _____

Name: _____
 Address: _____

 Phone: _____

Name: _____
 Address: _____

 Phone: _____

Name: _____
 Address: _____

 Phone: _____

My consent includes both verbal and written communication, which may include day-to-day observations of the following items (please initial beside each item you consent for):

- _____ Medical and physical health records and information
- _____ Behavioral Health and Psychiatric records (excluding psychotherapy notes)
- _____ Evaluation, assessment, and/or treatment information including occupational, physical, and/or speech therapies, audiological testing, etc.
- _____ Evaluation materials including results of psychiatric evaluation, social work contact, psychological testing, medical, evaluation, learning disabilities consultation, and education classification report.
- _____ Report of classroom and academic and/or vocational progress includes adjustments to teachers, peers, and general routines
- _____ School records

_____ Other: _____

(OVER)

Authorization for Disclosure of Health Information Page 2

I authorize the ARC of Essex County Staff to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

I understand that the ARC of Essex County is not responsible for any re-disclosure of the information released to any of above named individuals to any unauthorized entity. The ARC of Essex County is not responsible for what the other entity does with the information once it is received.

I understand I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the Executive Director at 123 Naylor Avenue, Livingston, NJ 07039. The revocation will be effective the date the Executive Director receives it.

I understand that I may refuse to sign this authorization. However, refusal to sign may limit the ARC of Essex County's ability to obtain information required to assess the support needs or services. This lack of information may affect the ARC of Essex County's ability to provide all available services. I also understand that I may inspect or copy any written information used or disclosed under this authorization.

This authorization expires on _____ or one year from the date of the individual's or legal guardian's signature.

Signature (or mark) of Individual or Legal Guardian Date

Print Name of Legal Guardian (if applicable)

If mark is provided in place of signature, the mark must be witnessed:

Witness Signature Title

Print Name of Witness

Check here if names are listed on an additional sheet []

