

Camp Hope Registration-2007

Camper's Name: _____

Camper's Address: _____
STREET CITY ZIP

Home Phone Number: _____

Age: _____ Date of Birth: _____ Sex: _____

T-Shirt Size: **Children's** S___ M___ L___ **Adult's** S___ M___ L___ XL___
 Adult XXL___ (available for \$3.00 extra sent with registration)
 AdultXXXL___ (available for \$3.00 extra sent with registration)

DDD Eligible? Yes___ No___

If eligible, are you requesting monetary support from DDD? Yes___ No___

Have you called your case manager to request payment? Yes___ No___

Case Manager's Name and Phone Number _____

MIS # _____

PLEASE ONLY CHECK THE WEEKS THAT YOU ARE ACTUALLY PLANNING ON ATTENDING, HAVE THE ABILITY TO PAY FOR, AND/OR HAVE ARRANGED PAYMENT FOR FROM OTHER SOURCES.

WEEK 1 JUNE 25 - JUNE 29 _____

WEEK 2 JULY 2 - JULY 6 _____ (closed July 4)
 (fee will be reduced 20% as we are closed for 1 day)

WEEK 3 JULY 9 - JULY 13 _____

WEEK 4 JULY 16 - JULY 20 _____

WEEK 5 JULY 23 - JULY 27 _____

WEEK 6 JULY 30 - AUG 3 _____

WEEK 7 AUG 6 - AUG 10 _____

WEEK 8 _____

Travel Session AUG 13 - AUG 17 _____
 (Space is limited to 50 campers this session)

OR

Autism Session AUG 13 - AUG 17 _____
 (Space is limited to 25 campers for this session)

Please attach recent picture of camper here
--

A \$40.00 REGISTRATION FEE MUST ACCOMPANY THIS SHEET OR IT WILL NOT BE PROCESSED!

FOR OFFICE USE ONLY

Registration Fee Paid _____	Information _____	Total Balance _____
Funding Sources _____	Application _____	DDD Paying _____
Family Visit Date _____	Transportation _____	FAF _____
Photo Release _____	Emergency _____	Fin/ Aid _____
Medication(s) _____	Financial Aid _____	Sliding Scale _____
		Balance _____

Actual Dates Attended Camp: wk# 1, wk# 2, wk# 3, wk# 4, wk# 5, wk# 6, wk# 7, wk# 8

Camp Hope 2007 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	\$415.00 per week
13 - 20 years old	1 staff : 5 campers	\$335.00 per week
21 years old and over (The ACE Program)	1 staff : 6 campers	\$360.00 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 1-2 times 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 **\$80.00 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 **\$670.00 per week** if they are in need of their own one-to-one aide that Camp Hope will provide. If you will be providing your own one-to-one aide, the regular camp fee of \$335.00 per week will be billed.

Travel Week:

All campers will be charged a flat rate of **\$435.00 per week** for the Travel Program. This fee includes all activities, costs for transportation and a 1 staff to 5 camper ratio. Campers who cannot participate in this ratio will not be accepted for this week.

Autism Week:

All campers will be charged a flat rate of **\$670.00 per week**, as they will be receiving their own one-to-one aides.

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-2007

Camper Name: _____ Nickname: _____

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

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

Father/Guardian

Mother/Guardian

Name _____

Name _____

Address _____

Address _____

Town _____

Town _____

Phone _____

Phone _____

Business Phone _____

Business Phone _____

Cell Phone # _____

Cell Phone # _____

Beeper # _____

Beeper # _____

MUST PROVIDE 2 NAMES AND NUMBERS

Emergency Contact Name: _____

Relationship to camper: _____

Emergency Contact Home Phone #: _____

Work #: _____

Cell or Pager #'s: _____

Emergency Contact Name: _____

Relationship to camper: _____

Emergency Contact Home Phone #: _____

Work #: _____

Cell or Pager #'s: _____

Participant's School Name or Work Place: _____

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

Participant's Teacher or Supervisor's Name: _____

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. Morris County Residents have the option of being picked up at St. Elizabeth's Campus.

Camper's Name: _____

Pick-Up and Drop off Address: Number, Street & City _____

(must be the same) _____

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

(Over, please)

2007

- A. Pictures of camper(s) and camper(s) 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 Emergency Treatment Release Form-2007
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 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 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)

Camp Hope Transportation Form-2007

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 _____

(Over, please)

2007

Camper's Name: _____

Camper's Address: _____

Phone #: _____

Parent/Guardian Name: _____

Parent /Guardian Address: _____

Parent /Guardian Home Phone #: _____

Work #: _____

Cell or Pager #'s: _____

Emergency Contact Name: _____

Relationship to camper: _____

Emergency Contact Home Phone #: _____

Work #: _____

Cell or Page #'s: _____

Camper's Primary Doctor: _____

Doctor's Phone: _____

Medical Insurance Name and Number: _____

Does this camper have seizures? Yes _____ No _____

If yes, type and duration: _____

Does this camper have any allergies? Yes _____ No _____

If yes, please list all: _____

Does this camper take any medication? Yes _____ No _____

If yes please list all medications: _____

Parent/Guardian Signature

Date

Camp Hope Participant Information-2007

Participant's Name: _____

Participant'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 Director and the staff to develop program activities that will be appropriate for the camper. It will also assist in making his / her experience as comfortable as possible. Your honest assessment will be most helpful since you know your child 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)

2007

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 has been involved outside of home (ex. School, Work, Special Olympics, Vacations, Camps, etc.)

Please describe, if any, post-seizure behavior and needs:

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-2007

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 understand 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)

2007

* **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 Naylor Ave.
Livingston, NJ 07039**

Camp Hope Health History and Examination Form-2007

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 Patient: _____

Address: _____ City: _____ Zip: _____

Mother 's Home Phone_ _____ Father's Home Phone Number _____

Mother's Day Phone Number _____ Father's Day Phone Number _____

Mother's Cell Phone Number _____ Father's Cell Phone Number _____

Sex: _____ Age: _____ Date of Birth: _____

Name of Physician _____

Address: _____

City & Zip: _____

Phone #: _____

Emergency Contact (s) if child is sick and must be picked up from camp:

(you must give two names) _____ Phone Number _____

_____ Phone Number _____

ALLEGIES

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 – 2007

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.

Medical Insurance Information:

Name of Policy Holder: _____

Relationship to Camper: _____

Provider: _____

Policy Number: _____

Group Number: _____

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

PHYSICIAN'S EXAMINATION-2007
(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

Name of Patient: _____

I have examined the individual named on this form.

Date of last examination: _____

EXAMINATION RESULTS (N=NORMAL)

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)

VACCINE	DATE	
DTP	_____	
TD (TETANUS/ DIPHTHERIA)	_____	
TETAN US	_____	
POLIO	_____	
MEASLES	_____	
MUMPS	_____	
RUBELLA	_____	
HAEMOPHILUS B	_____	
CHICKEN POX	_____	
HEPATITIS	_____	
YB Mantoux**	_____	results _____

**Within last years or administer current

Additional information for health care staff at camp: _____

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

Name of physician (please print) _____

Address _____

Phone # _____

Financial Aid Application - 2007

(A copy of your most recent W2 must accompany this application)

PLEASE PRINT

Name of Camper: _____

First

Middle

Last

Address: _____

Number and Street

Apt. Number

City

County

State

Zip Code

Is the person filling out the financial application the legal guardian of the camper? _____

If yes, and you are not the camper's mother or father, what is your relationship to the camper? _____

If you are not the legal guardian of the camper, who is the guardian? _____

Father/Guardian Name: _____

First

Middle

Last

Address _____

Number and Street

Apt. Number

City

State

Zip Code

Telephone: _____

Occupation: _____

Employer's Name : _____

Employer's Address: _____

City & Zip: _____

Father/Guardian's Gross Income for last year: _____

Father/Guardian's Taxable Net Income for last year: _____

(Over, please)

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: _____

Amount \$ _____

Authorized Signature X _____

FOR OFFICE USE ONLY

Check Number _____

Amount \$ _____

Money Order Number _____

Amount \$ _____