2016 JACK'S PLACE WEEK APPLICATION

CONTACT INFORMATION

CAMPER NAME (last, first): _____ **T-SHIRT SIZE:** Youth _____ or Adult _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: _____ ☐ Male ☐ Female **BIRTH DATE:** _____

AGE (as of camp session): _____ **COUNTY:** _____ **ETHNIC BACKGORUND** (optional): _____

HAS CAMPER ATTENDED ITC BEFORE?: ☐ Yes ☐ No

PARENTS/GUARDIANS FULL NAME: _____

ADDRESS (if different): _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL ADDRES: _____

**No person shall be excluded from programs because of race, religion, sexual preference, disability, or national origin.*

JACK'S PLACE WEEK | A traditional, overnight summer camp for campers ages 7 and up on the autism spectrum

SUNDAY, JULY 31 TO SATURDAY, AUGUST 6, 2016

Please send your application and financial form with your deposit as soon as possible to reserve your spot. If an agency or insurance company pays in full for your time at camp, you do not need to send a deposit.

NOTE: Please send all forms as soon as they are completed. Final acceptance/confirmation notices will be sent once all completed paperwork is received. We would advise you to mail us the completed application and financial form even if you do not have the physical form completed so that your spot is reserved. Then mail in the physical form upon completion but no later than 2 weeks prior to the camp session.

Mail applications to:

Indian Trails Camp
O-1859 Lake Michigan Dr. NW
Grand Rapids, MI 49534

Or Fax to: 1 (616) 677-2955

Phone: (616) 677-5251

For scholarship information, please contact:

Jack's Place for Autism Foundation
17360 W. 12 Mile Road, Suite 204
Southfield, MI 48076

Phone: (248) 443-7427

Fax: (248) 443-7145

CAMPER INFORMATION

CAMPER NAME: _____ **BIRTHDATE:** _____ ☐ Male ☐ Female

SESSION(S): _____ **NICKNAME, IF ANY:** _____

Check all applicable:

DISABILITY:

- ☐ Cerebral Palsy
- ☐ Muscular Distrophy
- ☐ Spina Bifida
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy
- ☐ Arthrogryposis
- ☐ Osteogenesis Imperf.
- ☐ Visual Impairment
- ☐ Autism/ASD
- ☐ Down's Syndrome
- ☐ Congenital Anomolies/Birth Defects: *Explain in detail*

- ☐ CHI (Closed Head Injury)
- ☐ Mental Impairment
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ Other *(please explain)*

CABIN MATE REQUESTS:

Please list any requests you have for cabin mates. We will do our best to accomodate your request.

1: _____

2: _____

COMMUNICATION:

- ☐ No communication difficulties
- ☐ Verbalizes, may be difficult to understand
- ☐ Non-verbal, yes/no responses only

Explain

Explain communication board or system

Additional helpful information

GENERAL HEALTH INFORMATION:

Does camper have seizures? ☐ Yes ☐ No

Frequency

Please describe the seizures, including length and severity

Common signs/conditions of seizure

Does the camper have allergies? ☐ Yes ☐ No

If yes, please explain agent and reaction in detail

Is the camper allergic to service dogs? ☐ Yes ☐ No

SPECIAL EQUIPMENT THAT CAMPER WILL BE BRINGING TO CAMP:

AMBULATION:

- ☐ Crutches
- ☐ Walker
- ☐ Wheelchair
- ☐ Elec. Wheelchair
- ☐ Scooter
- ☐ Other

EATING:

- ☐ Special Cup
- ☐ Special Dish
- ☐ Plate Guard
- ☐ Special Utensils
- ☐ Other

OTHER:

- ☐ Hoyer Lift
- ☐ Toilet Commode
- ☐ Communication Board
- ☐ Helmet
- ☐ Pace Maker
- ☐ Other

BRACING:

- ☐ AFO
- ☐ Hand Splint
- ☐ Other

ACTIVITIES OF DAILY LIVING

EATING:

- ☐ Independent
- ☐ Needs only food cut and plate set
- ☐ Must be fed

AMBULATION:

- ☐ Walks
- ☐ Independent
- ☐ Needs assistance *(describe)*:

- ☐ Depends on mobility device *(describe)*:

DRESSING & UNDRESSING:

- ☐ Independent
- ☐ Need assistance with fine motor skills
- ☐ Total assistance

PERSONAL CARE INFORMATION:

Check any which camper will need assistance with

- ☐ Showering
- ☐ Shaving
- ☐ Teeth-brushing
- ☐ Personal care: menstrual cycle

TOILETING

- ☐ Wears briefs
- ☐ Independent
- ☐ Needs assistance *(describe)*:

- ☐ Special bowel treatment/program *(describe)*:

How often does camper have bowel movements?

TRANSFERS:

Approx. weight: _____

- ☐ Independent
- ☐ Can bear weight for pivoting
- ☐ Must be lifted

Precautions that should be taken, if any:

BEHAVIOR NEEDS*:

Does camper have any behavior problems? ☐ Yes ☐ No

If yes, please describe:

Description:	*Frequency:*

How might we best accommodate these behavior problems?

ADJUSTMENT TO CAMP:

Any fears? If so, please explain:

OTHER

Anything else you would like us to know?

**For information on our behavior policy, please see our website.*

FINANCIAL FORM

CAMPER NAME: _____ **AGE:** _____ **COUNTY:** _____

1. Review the attached Level Determination Form and indicate below the level of care required for the camper.

☐ **LEVEL 1**	Minimal Dependence	$762 (6 days)
☐ **LEVEL 2**	Moderate Dependence	$1,116 (6 days)
☐ **LEVEL 3**	Complete Dependence/ Supervision 1:1	$1,536 (6 days)

If at any time after receipt of this form and camper application, the Camp Director and/or Health Director find the camper to require a different level of care than indicated, Indian Trails Camp reserves the right to change the level and fee accordingly. The camper and/or family will be notified if such change occurs.

2. Based on the above Level Determination, complete the following calculations.

SIX-DAY SESSION FEE: _____

TOTAL FEES DUE: _____

DEPOSIT (if applicable*): – _____

OTHER (additional amount towards balance, if desired): – _____

REMAINING BALANCE DUE: _____

**If a third party is being billed for the entire amount, a deposit is not required.*

3. Complete A, B, C, and/or D to indicate method and source(s) of payment. Note that the remaining balance per #2 above is due 1 week before the session start date for parent/guardian/self payments. If a scholarship is requested from Jack's Place for Autism Foundation and granted, that amount will be deducted from the indicated payment option.

A. CHECK **AMOUNT PAID WITH APPLICATION:** _____ **CHECK #:** _____

B. CREDIT CARD (Visa, Mastercad & Discover accepted)

AMT. TO CHARGE NOW: $_____ **AMT. TO CHARGE 1 WEEK PRIOR TO SESSION START DATE: $**_____

CARD #: _____ – _____ – _____ – _____ **EXP. DATE:** _____ / _____

NAME AS IT APPEARS ON CARD: _____ **PHONE:** _____

CARD BILLING ADDRESS: _____ **ZIP CODE:** _____

C. THIRD PARTY INSTALLMENT

If you expect a third party (such as Community Mental Health, Network 180, or insurance company) to pay for all or a portion of the camp fees, please complete this form. We highly recommend that you confirm the amount to be paid with the third party. If the third party pays less than the amount indicated, you will be responsible for the difference.

NAME OF ORGANIZATION TO BE BILLED: _____

CONTACT PERSON (e.g. supports coordinator, case manager)**:** _____

PHONE: _____ **FAX:** _____ **SEND BILL:** ☐ before session ☐ after session

EMAIL (if invoice may be emailed)**:** _____ **AMT. TO BE PAID: $** _____

D. SCHOLARSHIP ☐ I have a financial need and will request a scholarship

NOTE: Scholarship applications are due April 8. You will be notified by April 22. Applications will be accepted after April 8, but we cannot guarantee the availability of funding. Those applications will be processed if and when funding becomes available. Campers are eligible for a maximum of a 1 week scholarship.

For more information about refunds and cancellations, please see our policy on the website.

LEVEL DETERMINATION

LEVEL 1 (1:3)

Campers are provided one direct care counselor per three level 1 campers.

Level 1 is for campers who are able to perform most of their ADL's (Activities of Daily Living) independently.

Campers in this level take between 0-4 medications per day and do not have any current ongoing medical concerns.

Camper is independent with eating, or requires some verbal promps and/or minimal physical assistance (e.g. cutting up food).

Camper is independent with hygeine needs, or may require some verbal prompts to ensure completion or thoroughness.

Camper is independent with toileting, or requires minimal verbal prompts.

Camper is independent with practicing coping skills and staying focused on task at hand, or requires minimal verbal prompts or redirection.

LEVEL 2 (1:2)

Campers at this level are served with one direct care counselor per two campers.

Level 2 campers require some physical assistance but are independent in other areas of care.

Camper in Level 2 may not exceed 8 medications per day, and have minimal medical concerns.

Camper may require minimal physical assistance with accessing food at meals, and/or requires specialized diet/nutrition (e.g. pureed food).

Camper may require minimal physical assistance with hygeine needs to ensure completion or thoroughness.

Camper may require minimal physical assistance (e.g. wiping) with toileting.

Camper may require verbal promps or redirection with practicing coping skills and staying focused on task at hand.

Camper may be dependent on a mobility device (e.g. walker, cane, etc.) but is able to use this primarily independently.

LEVEL 3 (1:1)

Level 3 is reserved for campers who need on-to-one assistance the majority of the time due to medical or behavioral situations.

Medications may exceed 8 per day.

Campers who require medical treatments such as feeding tubes and severe seizure monitoring are automatically Level 3.

Camper may require full assistance with accessing food at meals.

Camper may require full assistance with most or all hygeine needs.

Camper may require full assistance with toileting, including transferring, diapering, and wiping.

Camper may require verbal prompts and redirection with practicing coping skills and staying focused on task at hand most to all of the time.

Camper may be dependent on a mobility device (e.g. manual/electric wheelchair, scooter, etc.) at all times, and may be independent with using it or need assistance.

Camper may be a flight-risk.

INSURANCE FORM

CAMPER NAME: _____ **SESSION:** Jack's Place Week

***IMPORTANT:** Indian Trails Camp, Inc. does not carry medical/accident insurance for campers. It is the responsibility of the camper/guardian to obtain adequate insurance coverage for any medical needs, including accidents.

I UNDERSTAND THE ABOVE: _____

Signature parent/guardian or adult camper

IS THE CAMPER COVERED BY MEDICAL INSURANCE?: ☐ Yes ☐ No

If yes, please list the camper's health insurance carrier (examples: Blue Cross, Medicare, PPOM, etc.)

_____

_____

POLICY NUMBER: _____

CONTRACT NUMBER: _____

CARD HOLDER'S NAME: _____

ADDITIONAL INFORMATION: _____

_____

CAMPER PHYSICAL FORM

All overnight summer campers must have a completed physical form on file with a date of September 1, 2015 or later. It must be signed by a physician and submitted at least 2 weeks prior to the session start date. It does not need to be mailed with the application.*

CAMPER NAME: _____ **DOB:** _____ **SEX:** _____

1. Applicant must be diagnosed with a physical or developmental disability, mental illness, Downs Syndrom, or autism.
2. Applicant must be capable of social interaction and participation in camp activities.
3. Applicant must be able to communicate needs through at least a yes or no response (e.g. eye blinks, headshake, use of communication board, etc.).

PRIMARY DIAGNOSIS/DISABILITY: _____

SECONDARY DIAGNOSIS: _____

MEDICAL HISTORY:

☐ Asthma/Respiratory problems

☐ Diabetes Type: _____

☐ Heart Defect ☐ Apnea

☐ Kidney Disorder ☐ Other

Immunizations (check all that have been issued and provide immunization dates):

☐ Diphtheria ____ / ____ / ____

☐ Pertussis ____ / ____ / ____

☐ Measles ____ / ____ / ____

☐ Polio ____ / ____ / ____

☐ Small Pox ____ / ____ / ____

☐ Rubella ____ / ____ / ____

Date of last Tetanus shot (must be within 10 years): ____ / ____ / ____

Does the camper frequently suffer from any of the following? (check all applicable)

☐ Headaches ☐ Sore Throat ☐ Ear Infections

Does the camper have known communicable diseases?

☐ Measles ☐ HIV Positive

☐ Chicken Pox

☐ Hepatitis ☐ A ☐ B ☐ C

☐ Other: _____

Allergies and Reaction:

CURRENT HEALTH: Height: _____ Weight: _____ BP: _____ HR: _____ RR: _____ Temp: _____ Pulse Ox: _____

OVERALL HEALTH CONDITION: _____

Other information for health care staff, including treatments to be continued at camp, activity restrictions, medically prescribed meal plan, or dietary restriction while at camp:

I have reviewed the camper's health history and discussed the camp program with the camper and/or parent/guardian. It is my opinion that the applicant is physically and emotionally fit to participate in the session at Indian Trails Camp (except as noted above).

_____

Physician's Signature *Date* *Physician's Office Name & Phone #*

**Overnight summer campers must have a camper physical form on file that is dated by the physician after 9/1/15 or within 12 months of when the camper attends camp. For example, if the physical is dated 8/1/15 and the camper is attending a June 2016 session, we would not need an updated form.*

MEDICATION RECORD

PLEASE LIST *ALL* MEDICATIONS. THE BACK OF THIS SHEET MAY BE USED IF NEEDED.

NOTE: Camp medications are distributed at 9 a.m., 12 noon, 2-4 p.m., 5 p.m., and 9 p.m.. Any deviations must be indicated by a physician. Only medications and dosages listed on this form will be approved on camp registration day. Any medications not listed on this form will not be administrated at camp without prior written approval of the physician. This includes ALL over the counter, non-prescription, and prescription medications. Medications must be brought in their original bottles. If you choose to bring them set up in a med container, pill bottles must still be brought to verify prescriptions. ****Please be sure to obtain written approval for any deviations of prescriptions written on bottle prior to camp registrations.**

NAME OF MEDICATION	DOSAGE	PRESCRIPTION, AS LISTED ON BOTTLE**	TIME(S) GIVEN
e.g. Depakote	*250 mg*	*3 tabs by mouth twice daily*	*9 a.m. and 9 p.m.*

HEALTH CARE AUTHORIZATION*

CAMPER NAME: _____

The medical facilities listed below are utilized by ITC. Please check the facility that you prefer be used for yourself or your child in the event of an emergency or need for additional medical treatment.

FACILITY:

- ☐ Mercy Health (approximately 15 miles east of ITC in downtown Grand Rapids)
- ☐ Spectrum Health (approximately 10 miles east of ITC in downtown Grand Rapids)
- ☐ Metro Health (approximately 15 miles southeast of ITC near M-6 and Byron Center Ave.)
- ☐ Other hospital: _____
- ☐ Spectrum Health Occupational Services (non-emergencies)
- ☐ No preference

I hereby give permission to Indian Trails Camp, which is licensed by the State of Michigan, to provide routine, non-surgical medical care; administer medications; order x-rays and/or routine tests; release any records necessary for insurance purposes; provide or arrange necessary related transportation for myself or my child; and to secure emergency medical and surgical treatment. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Indian Trails Camp management to secure and administer treatment, including hospitalization for the camper listed above, while attending Indian Trails Camp.

NOTE 1: In accordance with MCLA Act 116 of the Public Acts of 1973, as amended, and the rules for licensing camps, this authorization must be signed by the parent or guardian of a minor camper, unless there is religious objection.

NOTE 2: In accordance with MCLA Act 218 of the Public Acts of 1979, as amended, and the rules for licensing camps, this authorization must be signed by the authorized person of an adult camper, unless there is religious objection.

_____ _____

Signature *Date*

**For more information on our health care policy and procedure, please see our website.*

GENERAL LIABILITY RELEASE

I understand that Indian Trails Camp (ITC) assumes no responsibility for injuries that I or my child may sustain as a result of my or my child's physical condition, or resulting from my or my child's participation in any activities, programs, exercise, or the use of any facility, equipment, or other activities organized or sponsored by ITC. I expressly acknowledge that I assume risk for any and all injuries and illnesses that may result. In consideration of the privilege of using ITC, I hereby voluntarily release and discharge ITC, its agents, servants, and employees from any and all claims for injury, death, loss, or damage that I or my child may suffer. I understand that ITC is NOT responsible for personal property lost or stolen while members and/or program participants are using ITC facilities or on ITC premises.

Adult Camper or Parent/Legal Guardian *Date*

PHOTO RELEASE

I understand that Indian Trails Camp (ITC) loves to take pictures of guests enjoying themselves during their stay at camp, and that the photos are often used in marketing and promotional materials. ITC has my permission to use any media of me or my child at camp for purposes of promoting or describing ITC programs.

**If you prefer that photos of you or your child not be used, please let us know in writing prior to the camp experience.

Adult Camper or Parent/Legal Guardian *Date*