# 2017 SUMMER CAMP APPLICATION

## CAMPER INFORMATION

CAMPER'S NAME: ______________________________________________
Last First Middle

ADDRESS: ______________________________________________
Street City State Zip

TELEPHONE: (______)___________________ ☐ Male ☐ Female BIRTH DATE: _____/_____/______

COUNTY: ________________________________ ETHNIC BACKGROUND (optional): ________________________________

HAS CAMPER ATTENDED ITC BEFORE: ☐ Yes ☐ No

**EMAIL ADDRESS:** ______________________________________________

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

**T-SHIRT SIZE:** Youth ☐ S ☐ M ☐ L Adult ☐ S ☐ M ☐ L (please check one)

## PRIMARY CONTACT

________________________________ ☐ Parent ☐ Guardian ☐ Camper ☐ Other ☐ Authorized Pick Up

ADDRESS (if different): ______________________________________________
Street City State Zip

PRIMARY PHONE: ________________________ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

ALTERNATE PHONE: ________________________ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

**EMAIL ADDRESS:** ______________________________________________

## SECONDARY CONTACT

________________________________ ☐ Parent ☐ Guardian ☐ Camper ☐ Other ☐ Authorized Pick Up

ADDRESS (if different): ______________________________________________
Street City State Zip

PRIMARY PHONE: ________________________ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

ALTERNATE PHONE: ________________________ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

**EMAIL ADDRESS:** ______________________________________________

## ALTERNATIVE CONTACT #1

________________________________ ☐ Authorized Pick Up

PRIMARY PHONE: ________________________ ALTERNATE PHONE: ________________________

## ALTERNATIVE CONTACT #2

________________________________ ☐ Authorized Pick Up

PRIMARY PHONE: ________________________ ALTERNATE PHONE: ________________________

## SESSION—CAMP ALEC

**A 5 minute unedited video with examples of your child communicating may be requested, but is not required at this time.**

Primary mode of communication at home: ______________________________

Primary mode of communication at school: ______________________________

How does your child indicate "YES"? ______________________________

How does your child indicate "NO"? ______________________________

Is your child's Yes/No response: ☐ Reliable ☐ Inconsistent

Approximate Language Comprehension Level: ______________________________

Verbal Abilities: ______________________________

Does your child use any gestures consistently for communication? Please list: ______________________________

______________________________

______________________________

Communications Systems: Check all that apply: ☐ Manual Communication Board ☐ Speech Generating Device

Device Name ______________________________

Device page set (if applicable): ______________________________

______________________________

How does the child access the device? (Please explain): ______________________________

______________________________

Direct Selection: ______________________________

Scanning: ______________________________

Switch Type and Access Site: ______________________________

______________________________

Switch Accuracy (Estimate % Correct): ______________________________

Tendency to hit switch more than once: ______________________________

Briefly describe vocabulary organization of child's device (e.g. # of pages or levels; # of pictures or words per overlay):

______________________________

______________________________

______________________________

______________________________

______________________________

Is the device mounted to a wheelchair? ☐ Yes ☐ No

How long has the child had the device? ______________________________

**When learning, my child works best in:**

- [ ] 15-minute sessions
- [ ] 30-minute sessions
- [ ] Individual sessions
- [ ] Group sessions
- [ ] With 1-1 behavioral support
- [ ] With hand-over-hand support

**Status of reading and writing skills:**

Knows most of the letters most of the time? ☐ Yes ☐ No

Interested and engaged during book sharing? ☐ Yes ☐ No

Books/subjects that are most interesting or motivating for your child: ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

How does your child use their device? Check all that apply:

- [ ] Independently
- [ ] Answers questions only
- [ ] One word response
- [ ] WIth language models
- [ ] With verbal prompts
- [ ] Preprogrammed phrases/responses
- [ ] Builds own phrases/sentences
- [ ] Spells words/uses word prediction
- [ ] Has access to core volcabulary
- [ ] Initiates social exchanges
- [ ] Can signal if he/she needs help, please describe ______________________________

Would someone unfamiliar with your child's customized pages be able to model language and help your child locate vocabulary? ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Please describe approximate reading level: ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Please describe how your child accesses books: ______________________________

______________________________

______________________________

______________________________

Please describe how your child writes: ______________________________

______________________________

______________________________

______________________________

Please describe approximate writing level: ______________________________

______________________________

______________________________

______________________________

What does attending Literacy Camp mean to you? ______________________________

______________________________

______________________________

______________________________

## Please attach your child's current IEP to this application.

## 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 |
| __LEVEL 2 | Moderate Dependence | $1,116 |
| __LEVEL 3 | Complete Dependence/Supervision 1:1 | $1,536 |

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.**

**Total Fees Due Based on Tier:** $__________________

**Less payments sent with application:**

Deposit (non-refundable $100): - $__________________

Other (additional amount towards balance, if desired): - $__________________

**Remaining Balance Due:** **$**__________________

**3. Complete A, B, C and/or D to indicate method & source(s) of payment. Note that the remaining balance per #2 above is due by June 15, 2017 for parent/guardian/self payments.**

A. Check: Amount paid with application _________ Check # _________

B. Credit Card (Visa, Mastercard & Discover accepted):

Amount to charge now $_________ Amount to charge on June 15, 2017 $_________

Card # _________ - _________ - __________ - ___________ Exp Date ____/____

Name as it appears on card ________________________________________ Ph # (_____)____________

Card billing address ___________________________________________________ Zip Code __________

C. Third Party Payment:

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 (eg. supports coordinator, case manager): ________________________________________

Ph # (_____)____________________ Fax # (_____)____________________

Email address if invoice may be emailed: ______________________________________________________

Amount to be paid: _____________________________

Send bill: _______before (or) ______after session.

D. Scholarship

___ I have a financial need and will request a scholarship

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

## 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 (Cognitive Impairment)
  - ☐ 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.*

# 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 prompts and/or minimal physical assistance (e.g. cutting up food).

Camper is independent with hygiene 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 hygiene needs to ensure completion or thoroughness.

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

Camper may require verbal prompts or redirection with practicing coping skills and staying focused on the 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 hygiene 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:** ______________________________

Camp ALEC Session

***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 of 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 campers must have a completed physical form on file dated within 12 months of the session(s) attending. 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 Syndrome, 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 #*

## 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.* |
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## 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* |

## 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) & Camp ALEC love 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 & Camp ALEC have my permission to use any media of me or my child at camp for purposes of promoting or describing ITC & Camp ALEC 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*

## SUMMER CAMP CHECKLIST

| DATE SENT | FORM | NEED BY |
|---|---|---|
| ________________ | **14-Page Application** **(NOTE: must include $100 deposit to reserve your spot)** | **ASAP** *Note: Applications are due by May 30, 2017. After this date applications will still be considered if slots are still available. |
| ________________ | **Financial Form** | **ASAP** *Note: Send with application |
| ________________ | **Level of Determination** | **ASAP** *Note: Send with application |
| ________________ | **Most Recent IEP** | **ASAP** *Note: Send with application |
| ________________ | **Insurance Card** | **ASAP** *Note: Send with application |
| ________________ | **Physical Form** | **3 weeks prior to camp session** |

**DROP OFF TIMES FOR CAMP ALEC IS 4:00PM - 5:00PM**

**PICK UP TIME FOR CAMP ALEC IS 10:00 AM.**

There will be a presentation delivered by Karen and David at 10:00AM sharp. Parents will receive an important overview of the week's activities and recommended strategies. You will also have a chance to meet with your child's Literacy Counselor and Camp Counselor at this time.

**This session has only 20 slots and will fill up fast. Please send your application, financial form, level of determination, IEP and copy of insurance card along with your $100 deposit as soon as possible to reserve your spot. If an agency or insurance company pays in full for your session your initial deposit will be returned to you.**

**IF YOUR CAMPER HAS BEEN ACCEPTED TO CAMP ALEC YOUR DEPOSIT WILL NOT BE REFUNDED.**

**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, financial form, level of determination, IEP and copy of insurance card 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 3 weeks prior to camp session.**

**APPLICATIONS ARE DUE MAY 30, 2017 AT WHICH TIME WE WILL OPEN UP ANY AVAILABLE SPOTS TO THOSE WAITLISTED.**

**We will continue to accept applications after this date if spots are still available.**

**Make checks payable to Indian Trails Camp.**

**Mail applications to:**

**Camp ALEC**
**C/O Gina Cunningham**
**44125 Cottisford Street**
**Northville, MI 48167**

**Email to: campalecinfo@gmail.com**

**Or Fax to:**
**1(248) 869-6073**

**For additional information please contact us at campalecinfo@gmail.com.**