

Town of Clifton Park Full Day Camp – Autism Program Additional Application

SECTION 1: PERSONAL INFORMATION

Camper Name: _____ Gender: Male Female

- New camper
- Returning camper

- Session 1: **July 16 - 20**, 2012 (Collins Park) 9am – 12pm Fee: \$50
- Session 2: **July 23 - 27**, 2012 (Collins Park) 9am – 12pm Fee: \$50

(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

Age: _____ Date of Birth: _____

Diagnosis: _____

In order to provide a safe camping experience, please attach an IEP if it addresses behavioral needs and/or a behavior plan if one has been written.

My child does not have a behavior plan or an IEP which addresses behavioral needs.

Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____
_____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____
Phone Number: _____

Surgeon: _____ Address: _____
Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
- Physical Aggression YES NO Details: _____
- Sensitive to touch YES NO Details: _____
- Verbally abusive YES NO Details: _____
- Self-stimulating behavior YES NO Details: _____
- Temper tantrums YES NO Details: _____
- Other behaviors of concern: _____
- _____
- _____

BEHAVIORS SCHOOL REPORTS TO YOU [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
<input type="checkbox"/> Loud	<input type="checkbox"/> Constant talking	<input type="checkbox"/> Interrupts peers and teachers
<input type="checkbox"/> Know it all	<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Difficulty in following direction
<input type="checkbox"/> Extremely busy	<input type="checkbox"/> Distractible	<input type="checkbox"/> Misunderstands expectations
<input type="checkbox"/> Always appropriate	<input type="checkbox"/> Always on task	<input type="checkbox"/> Teachers don't see any disability
<input type="checkbox"/> Constantly weepy	<input type="checkbox"/> Very needy	<input type="checkbox"/> Meltdown if routine is changed
		<input type="checkbox"/> No problems for cycle of time then many problems for cycle of time

Please explain all checked behaviors. _____

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BEHAVIORS YOU SEE IN HOME AND COMMUNITY [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
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Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

List prior group experience (dates and perceived effectiveness): _____

List counseling services (current/past providers): _____

Language skills (Check one.)
 Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

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Family Physician: _____ Address: _____

Phone Number: _____

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Phone Number: _____

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Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

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Check all that apply.

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Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

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Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____

Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
- Physical Aggression YES NO Details: _____
- Sensitive to touch YES NO Details: _____
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- Temper tantrums YES NO Details: _____
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List counseling services (current/past providers): _____

Language skills (Check one.)

- Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

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Address: _____ Phone Number: _____

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Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
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List counseling services (current/past providers): _____

Language skills (Check one.)

- Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

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Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

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(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

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Person Completing Application: _____ Relationship to Camper: _____

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SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

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SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
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<input type="checkbox"/> Loud	<input type="checkbox"/> Constant talking	<input type="checkbox"/> Interrupts parents, peers, siblings
<input type="checkbox"/> Know it all	<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Difficulty in following direction
<input type="checkbox"/> Extremely busy	<input type="checkbox"/> Distractible	<input type="checkbox"/> Misunderstands expectations
<input type="checkbox"/> Always appropriate	<input type="checkbox"/> Always on task	<input type="checkbox"/> Don't see any disability at home
<input type="checkbox"/> Constantly weepy	<input type="checkbox"/> Very needy	<input type="checkbox"/> Meltdown if routine is changed
		<input type="checkbox"/> No problems for cycle of time then many problems for cycle of time

Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

List prior group experience (dates and perceived effectiveness): _____

List counseling services (current/past providers): _____

Language skills (Check one.)
 Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

- Camp is available on a first come first served basis. Acceptance into camp is contingent upon review of a complete application by the camp director, social worker and medical advisor.
- Applications will be reviewed based on the child's appropriateness for camp.
- Enrollment will be limited to 30 campers per session.

Who cannot attend?

- Children with extreme behavioral challenges;
- Children who exhibit aggressive or self-abusive behavior;
- Children who are a flight risk; or
- Children who require constant one-to-one attendant care.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

Signature

Date

Town of Clifton Park Full Day Camp – Autism Program Additional Application

SECTION 1: PERSONAL INFORMATION

Camper Name: _____ Gender: Male Female

- New camper
- Returning camper

- Session 1: **July 16 - 20**, 2012 (Collins Park) 9am – 12pm Fee: \$50
- Session 2: **July 23 - 27**, 2012 (Collins Park) 9am – 12pm Fee: \$50

(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

Age: _____ Date of Birth: _____

Diagnosis: _____

In order to provide a safe camping experience, please attach an IEP if it addresses behavioral needs and/or a behavior plan if one has been written.

My child does not have a behavior plan or an IEP which addresses behavioral needs.

Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____
_____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

Wandering YES NO Details: _____

Physical Aggression YES NO Details: _____

Sensitive to touch YES NO Details: _____

Verbally abusive YES NO Details: _____

Self-stimulating behavior YES NO Details: _____

Temper tantrums YES NO Details: _____

Other behaviors of concern: _____

BEHAVIORS SCHOOL REPORTS TO YOU [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
<input type="checkbox"/> Loud	<input type="checkbox"/> Constant talking	<input type="checkbox"/> Interrupts peers and teachers
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		<input type="checkbox"/> No problems for cycle of time then many problems for cycle of time

Please explain all checked behaviors. _____

Town of Clifton Park Full Day Camp – Autism Program Additional Application

BEHAVIORS YOU SEE IN HOME AND COMMUNITY [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

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Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

List prior group experience (dates and perceived effectiveness): _____

List counseling services (current/past providers): _____

Language skills (Check one.)

- Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

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What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

- Camp is available on a first come first served basis. Acceptance into camp is contingent upon review of a complete application by the camp director, social worker and medical advisor.
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As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

Signature

Date

Town of Clifton Park Full Day Camp – Autism Program Additional Application

SECTION 1: PERSONAL INFORMATION

Camper Name: _____ Gender: Male Female

- New camper
- Returning camper

- Session 1: **July 16 - 20**, 2012 (Collins Park) 9am – 12pm Fee: \$50
- Session 2: **July 23 - 27**, 2012 (Collins Park) 9am – 12pm Fee: \$50

(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

Age: _____ Date of Birth: _____

Diagnosis: _____

In order to provide a safe camping experience, please attach an IEP if it addresses behavioral needs and/or a behavior plan if one has been written.

My child does not have a behavior plan or an IEP which addresses behavioral needs.

Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____
_____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
- Physical Aggression YES NO Details: _____
- Sensitive to touch YES NO Details: _____
- Verbally abusive YES NO Details: _____
- Self-stimulating behavior YES NO Details: _____
- Temper tantrums YES NO Details: _____
- Other behaviors of concern: _____
- _____
- _____

BEHAVIORS SCHOOL REPORTS TO YOU [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
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<input type="checkbox"/> Know it all	<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Difficulty in following direction
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Please explain all checked behaviors. _____

Town of Clifton Park Full Day Camp – Autism Program Additional Application

BEHAVIORS YOU SEE IN HOME AND COMMUNITY [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

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		<input type="checkbox"/> No problems for cycle of time then many problems for cycle of time

Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

List prior group experience (dates and perceived effectiveness): _____

List counseling services (current/past providers): _____

Language skills (Check one.)

- Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

- Camp is available on a first come first served basis. Acceptance into camp is contingent upon review of a complete application by the camp director, social worker and medical advisor.
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Who cannot attend?

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- Children who require constant one-to-one attendant care.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

Signature

Date

Town of Clifton Park Full Day Camp – Autism Program Additional Application

SECTION 1: PERSONAL INFORMATION

Camper Name: _____ Gender: Male Female

- New camper
- Returning camper

- Session 1: **July 16 - 20**, 2012 (Collins Park) 9am – 12pm Fee: \$50
- Session 2: **July 23 - 27**, 2012 (Collins Park) 9am – 12pm Fee: \$50

(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

Age: _____ Date of Birth: _____

Diagnosis: _____

In order to provide a safe camping experience, please attach an IEP if it addresses behavioral needs and/or a behavior plan if one has been written.

My child does not have a behavior plan or an IEP which addresses behavioral needs.

Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____
_____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____
Phone Number: _____

Surgeon: _____ Address: _____
Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
- Physical Aggression YES NO Details: _____
- Sensitive to touch YES NO Details: _____
- Verbally abusive YES NO Details: _____
- Self-stimulating behavior YES NO Details: _____
- Temper tantrums YES NO Details: _____
- Other behaviors of concern: _____
- _____
- _____

BEHAVIORS SCHOOL REPORTS TO YOU [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
<input type="checkbox"/> Loud	<input type="checkbox"/> Constant talking	<input type="checkbox"/> Interrupts peers and teachers
<input type="checkbox"/> Know it all	<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Difficulty in following direction
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<input type="checkbox"/> Always appropriate	<input type="checkbox"/> Always on task	<input type="checkbox"/> Teachers don't see any disability
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Please explain all checked behaviors. _____

Town of Clifton Park Full Day Camp – Autism Program Additional Application

BEHAVIORS YOU SEE IN HOME AND COMMUNITY [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

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		<input type="checkbox"/> No problems for cycle of time then many problems for cycle of time

Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

List prior group experience (dates and perceived effectiveness): _____

List counseling services (current/past providers): _____

Language skills (Check one.)
 Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp? _____

Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

- Camp is available on a first come first served basis. Acceptance into camp is contingent upon review of a complete application by the camp director, social worker and medical advisor.
- Applications will be reviewed based on the child's appropriateness for camp.
- Enrollment will be limited to 30 campers per session.

Who cannot attend?

- Children with extreme behavioral challenges;
- Children who exhibit aggressive or self-abusive behavior;
- Children who are a flight risk; or
- Children who require constant one-to-one attendant care.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

Signature

Date

Town of Clifton Park Full Day Camp – Autism Program Additional Application

SECTION 1: PERSONAL INFORMATION

Camper Name: _____ Gender: Male Female

- New camper
- Returning camper

- Session 1: **July 16 - 20**, 2012 (Collins Park) 9am – 12pm Fee: \$50
- Session 2: **July 23 - 27**, 2012 (Collins Park) 9am – 12pm Fee: \$50

(Check both boxes if the camper would like to attend both weeks)

Address: _____ Phone Number: _____

Age: _____ Date of Birth: _____

Diagnosis: _____

In order to provide a safe camping experience, please attach an IEP if it addresses behavioral needs and/or a behavior plan if one has been written.

My child does not have a behavior plan or an IEP which addresses behavioral needs.

Person Completing Application: _____ Relationship to Camper: _____

Address: _____ Phone Number: _____
_____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PHYSICIAN INFORMATION

Family Physician: _____ Address: _____

Phone Number: _____

Surgeon: _____ Address: _____

Phone Number: _____

SECTION 3: GENERAL MEDICAL INFORMATION

Does the camper have a seizure disorder? YES NO

Describe how often, type, duration, characteristics, etc. _____

List any other medical needs: _____

SECTION 4: SOCIAL AND BEHAVIORAL INFORMATION

Check all that apply.

- Wandering YES NO Details: _____
- Physical Aggression YES NO Details: _____
- Sensitive to touch YES NO Details: _____
- Verbally abusive YES NO Details: _____
- Self-stimulating behavior YES NO Details: _____
- Temper tantrums YES NO Details: _____
- Other behaviors of concern: _____
- _____
- _____

BEHAVIORS SCHOOL REPORTS TO YOU [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Quiet	<input type="checkbox"/> Needs prompts to participate
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Please explain all checked behaviors. _____

Town of Clifton Park Full Day Camp – Autism Program Additional Application

BEHAVIORS YOU SEE IN HOME AND COMMUNITY [Check all that apply. Please mark an (*) next to those items that require the intervention of a Teacher or an Aide.]

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Please explain all checked behaviors. _____

List all psychiatric and medical diagnoses: _____

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List counseling services (current/past providers): _____

Language skills (Check one.)
 Typical or advanced for age Has significant verbal limitations Has minor verbal limitations

SECTION 5: ADDITIONAL INFORMATION

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? _____

How does the camper react when upset or frustrated? _____

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Is there any additional assistance the camper may require while at camp? _____

SECTION 6: CAMPING AND LEISURE INTERESTS

List previous camping experiences (day/overnight). _____

Did the camper enjoy the experience(s) and adjust well? _____

What were the camper's three favorite things about camp? _____

SECTION 7: DINING FACTS

Name: _____ Medication Precautions: _____

Program: _____ Food Allergies: _____

Date: _____ Update: _____ Special Diet: _____

Does the child have any difficulties with dining other than those listed above? YES NO (If yes, please describe.)

SECTION 8: ADMISSION INFORMATION

Admissions:

- Camp is available on a first come first served basis. Acceptance into camp is contingent upon review of a complete application by the camp director, social worker and medical advisor.
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Camper Name

Signature

Date