Camp Spectacular 2024 Application

ENROLLMENT INFORMATION

☐ New camper – All new campers must participate in a pre-camp screening.

☐ Returning camper – Years of attendance: _____

☐ My child attends Spectrum Life Strategies with Steve Szalowski

Staple current photo here

Session Preference (number sessions in order of preference)

_____ Total number of sessions the camper would like to attend.

_____ Session 1: July 22-July 26 (entering 6th grade-entering 12th grade)

_____ Session 2: July 29-August 2 (entering 6th grade-entering 12th grade)

_____ Session 3: August 5-August 9 (entering 3rd grade-entering 12th grade)

Payment Method: All payments must be paid in full one week prior to attending camp.

Checks made payable to *Center for Disability Services*.

☐ I have called Lori Hunt (518-437-5513) and paid $_____ via credit card.

☐ Payment will come from an OPWDD approved self-directed plan.

Fiscal Intermediary contact, name, email, phone number: _____

☐ The camper has been awarded a grant from: _____ in the amount of $_____

T-Shirt Size (check one)

YOUTH: ☐ Small ☐ Medium ☐ Large

ADULT: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large

PERSONAL INFORMATION

Camper Name: _____ Camper Preferred Name: _____

Phone Number: _____ Preferred Pronouns: _____

Address (street/city/state/zip): _____

County: _____ Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ Other

Person Completing Application: _____ Relationship to Camper: _____

Phone Number ☐ same as camper: _____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

Diagnosis (check all that apply)

☐ Autism Spectrum Disorder ☐ Asthma ☐ Other (Please specify):_____

☐ ADD/ADHD ☐ Social Anxiety ☐

Allergies (check all that apply)

☐ No Known Drug Allergies ☐ No Known Food Allergies ☐ Latex ☐ Seasonal ☐ Environmental

☐ Other Allergies: _____

☐ Anaphylaxis ☐ Epi-Pen

SOCIAL AND BEHAVIORAL INFORMATION

In order to best prepare for and meet the needs of the camper, please provide accurate and detailed information. Submit all behavior support plans and Individualized Education Plans (IEPs) with this application.

Check all that apply.

Physical aggression	☐ YES	☐ NO	Details: _____
Self-stimulating behavior	☐ YES	☐ NO	Details: _____
Sensitive to touch	☐ YES	☐ NO	Details: _____
Temper tantrums	☐ YES	☐ NO	Details: _____
Verbally abusive	☐ YES	☐ NO	Details: _____
Wandering	☐ YES	☐ NO	Details: _____

BEHAVIORS SCHOOL REPORTS TO YOU

Check all that apply. Give details for those items that require the intervention of a Teacher or Aide and what methods should be used to handle these behaviors.

☐ Withdrawn	☐ Quiet	☐ Needs prompts to participate
☐ Loud	☐ Constant talking	☐ Interrupts peers and teachers
☐ Know it all	☐ Disrespectful	☐ Difficulty in following direction
☐ Extremely busy	☐ Distractible	☐ Misunderstands expectations
☐ Always appropriate	☐ Always on task	☐ Teachers don't see any disability
☐ Constantly weepy	☐ Very needy	☐ Meltdown if routine is changed

Explain all checked behaviors. _____

_____

_____

BEHAVIORS YOU SEE AT HOME AND COMMUNITY

Check all that apply. Give details for what methods should be used to handle these behaviors.

☐ Withdrawn	☐ Quiet	☐ Needs prompts to participate
☐ Loud	☐ Constant talking	☐ Interrupts parents, peers, siblings
☐ Know it all	☐ Disrespectful	☐ Difficulty in following direction
☐ Extremely busy	☐ Distractible	☐ Misunderstands expectations
☐ Always appropriate	☐ Always on task	☐ Don't see any disability at home
☐ Constantly weepy	☐ Very needy	☐ Meltdown if routine is changed
		☐ No problems for cycle of time followed by many problems for cycle of time

Explain all checked behaviors. _____

_____

_____

Other behaviors of concern: _____

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

How does the camper react when upset or frustrated? _____

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

DINING FACTS

Food Allergies: _____

Special Diet/Nutrition: _____

Medical Precautions: _____

Does the camper have any difficulties with dining other than those listed above? ☐ YES ☐ NO

If yes, please request a detailed dining facts form from the camp office and submit with the application.

CONSENT

CONSENT TO TREAT

In the event of an emergency wherein any of the listed physicians are not available, I give my consent to provide treatment and to conduct any tests by appropriate Ellis Hospital Staff on duty who are required to render necessary medical care.

CONSENT TO ATTEND AND PARTICIPATE

I give permission for the camper named below to attend Camp Spectacular and participate in all activities. I also agree not to send this person to Camp if exposed to a contagious disease within 21 days of the date the applicant is to report to Camp, and I will notify the Camp Director immediately.

REFUND & PAYMENT POLICY- Please read carefully!

If the below named camper cancels prior to the beginning of the session the camp fee will be refunded. If the below named camper is sent home due to medical reasons determined by the camp health director, the camp fee will be prorated and refunded. If the below named camper does not wish to remain at camp, or if the below named camper is sent home due to behavioral issues, a refund will be prorated and refunded contingent upon the vacancy being filled.

MEDICATION AUTHORIZATION (check one)

☐ NO The below named camper does not need to take any routine medication (prescription or over-the-counter) while at camp.

☐ YES The below named camper will need to take medication while at camp. I authorize administration of the prescribed medications.

PERMISSION TO APPLY SUNSCREEN AND BUG SPRAY

I give the staff at Camp Spectacular permission to apply the bug spray and sunscreen that I have provided to the below named camper.

RELEASE OF CONTACT INFORMATION

☐ YES
☐ NO

I give my permission to Camp Spectacular to release my contact information to the families of other campers. The release of this information is for the sole purpose of arranging social interactions among the campers and organizing carpool groups. I understand that my contact information will not be released to any other entity.

WAIVER

All the information provided in this application is accurate and complete to the best of my knowledge.

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

Camper Name

_____ _____

Parent/Guardian/Advocate Signature *(please print out and sign)* **Date**

MARKETING AND MEDIA RELEASE FORM

Name of Camper: _____

I hereby grant to the Center for Disability Services ("CFDS") permission to film, video, and/or photograph (collectively, the "Media") me, or those for whom I am legally responsible.

I understand and acknowledge that CFDS may use the Media for advertisement, promotional, and/or marketing materials, in any and all form now known or later devised. I hereby grant to CFDS a perpetual, irrevocable, fully paid, royalty-free, universal and unconditional right to: (a) use, portray, publish, copy, distribute, display and generally use all or portions of the Media, including, without limitation, the name(s) of those depicted, fictional names (if any), voice, photographs, words, images, personality or other likeness (collectively, "Publicity Rights"); and, (b) copy, distribute, perform, display, and create derivative works from any copyright protected works or materials developed or created based in whole or in part on, or arising from or related to the Publicity Rights, for advertising, distribution, marketing, promotion, publicity, sales or any other lawful commercial purpose, in any form or manner, in whole or in part, in any electronic or non-electronic medium now known or later devised, as it relates to promoting CFDS. I also waive any right to inspect or approve the finished product.

In addition, I hereby release and hold harmless, CFDS, together with its respective employees, agents, affiliates, sponsors, or other representatives, from any and all claims, demands, or causes of action arising out of the use of the Media or Publicity Rights in accordance with the terms of this release form. I understand and agree that neither I, nor those for whom I am legally responsible, will be compensated in any way for the use of the Media or Publicity Rights.

Parent/Guardian/Advocate Signature: _____ **Date:** _____

Parent/Guardian/Advocate Name (printed): _____

*** If this release form is being signed on behalf of a minor, the signatory above acknowledges that he or she is over the age of 18 and is the parent and/or legal guardian of:

Minor's name (printed): _____ **Age:** _____

NO PHOTOS OR VIDEOS

Parent/Guardian/Advocate Signature: _____ **Date:** _____

Parent/Guardian/Advocate Name (printed): _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I have received a copy of the *Notice of Privacy Practices of the Center for Disability Services, Inc*. The Notice describes how my health/clinical information may be used or disclosed. I understand that I should read the Notice carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice from the Center's web site www.cfdsny.org or by contacting the Privacy Officer at 518-944-2129.

Camper Name: _____
(print)

Camper Entity Number: N/A

**Signature: _____ Date: _____

**As the representative of the above individual, I acknowledge receipt of the Notice on his/her behalf.

Signature: _____ Date: _____

For CFDS use only

Y	Yes – Individual received & acknowledgement was signed
R	Individual received and refused to sign
U	Individual received and unable to sign

EMERGENCY CONTACT INFORMATION

This form will be available at check-in for review and modifications, as necessary.

Camper Name: _____ Address: _____

Home Phone: _____ _____

Primary Contact

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Alternate contacts in the event of an emergency, illness or injury

List individuals granted permission to assist in the event of an emergency, illness or injury. Please inform the individual(s) prior to the camp session that they have been listed as a contact.

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Car Pool Permission

Your child will only be allowed to leave camp with individuals authorized above or on the list below. Any changes or additions must be given in writing to the camp administration. List babysitters, car pool partners and any friends or relatives you anticipate may pick up your child. Parents, guardians and emergency contacts already listed above DO NOT need to be listed again below.

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

_____ _____

Parent/Guardian/Advocate Signature (please print and sign) **Date**

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SWIMMING PERMISSION

Does the camper have permission to swim while at camp? ☐ YES ☐ NO

Does the camper enjoy swimming? ☐ YES ☐ NO

If the camper does not enjoy swimming, will he or she want to be at the pool during swim time? ☐ YES ☐ NO

Will the camper enjoy dipping his or her feet in the water? ☐ YES ☐ NO

What level swimmer is the camper? (check one)

- ☐ **No Previous Swimming Experience** – camper has never swam before
- ☐ **Non-Swimmer** – will enter water with assistance
- ☐ **Beginner** – has swam before; limited swimming ability
- ☐ **Advanced Beginner** – can move through the water using a floatation device or mild physical assistance
- ☐ **Intermediate** – can support self in water, go under water
- ☐ **Advanced** – can independently swim

What type of personal flotation device best suits the camper?

- ☐ Aqua jogger
- ☐ Floatation Vest
- ☐ Other: _____

Are there any swimming restrictions? ☐ YES ☐ NO Details: _____

_____

Please note.

1. An American Red Cross certified lifeguard is on duty at all times during swimming activities.
2. All campers must have a signed swimming permission form to participate in swimming activities at camp.

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

Camper Name

_____ _____

Parent/Guardian/Advocate Signature **Date**

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HEALTH ASSESSMENT

Camper Name: _____ Date of Birth: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Primary Physician: _____ Phone Number: _____

Address: _____

Surgeon (if applicable): _____ Phone Number: _____

Address: _____

Specialist (if applicable) _____ Phone Number: _____

Address: _____

ALLERGIES (check all that apply)

- ☐ No Known Drug Allergies
- ☐ No Known Food Allergies
- ☐ Latex
- ☐ Seasonal
- ☐ Environmental
- ☐ Food: _____
- ☐ Medication: _____
- ☐ Other: _____

☐ Epi-Pen

Allergy: _____

IMMUNIZATIONS

Attach a copy of the camper's complete vaccination record.

PHYSICAL EXAM

Camper Name: _____ Date of Birth: _____

This section must be completed by a licensed medical professional. The exam must be within 12 months of the last day of attendance at camp. You may either submit the information on this form or attach a similar form required for school or other extra-curricular activities.

SYSTEMS REVIEW

Height: _____ Weight: _____ Pulse: _____ BP: _____ Respiration: _____

✓ **IF WITHIN NORMAL LIMITS.**

WNL	System	Notes
☐	General Appearance	
☐	Abdomen (hernia)	
☐	Breasts	
☐	Chest-lungs	
☐	Ears/Hearing	
☐	Extremities	
☐	Eyes/Vision	
☐	Heart	
☐	Mouth	
☐	Neck/Thyroid	
☐	Neurological	
☐	Pelvic/Genitalia/Rectal	
☐	Skin	

MEDICAL HISTORY

Chronic Health Problems	
Recent Illnesses	
Operations/Injuries	

RECOMMENDATIONS / RESTRICTIONS WHILE AT CAMP

_____

_____

I have examined this individual and have reviewed his/her medical history. It is my opinion that he/she is physically able to participate in camp activities at Camp Spectacular, except as noted above.

_____ _____ _____

Physician Signature **Physician Name** **Date**

MEDICATION RECORD

Camper Name: _____ Date of Birth: _____

- ⇨ A doctor's order is required for all prescription medications, over-the-counter medications, and natural remedies, including topical treatments.
- ⇨ Any medication that has been added or discontinued prior to arrival at camp must be accompanied by a written doctor's order or a copy of the prescription.

☐ This individual will not take any routine medications while attending camp.

☐ This individual will take routine medications while attending camp.

STANDING EMERGENCY ORDERS

The following over-the-counter medications are stocked in the Health Center and will be used to manage illness and/or injury of this individual. Check all that are acceptable to treat the individual.

☐ **Neosporin, Bacitracin or Triple Antibiotic Ointment** – Apply thin layer to minor cuts or skin abrasions BID PRN.

☐ **Sunscreen SPF 30** – PABA free to all exposed skin surfaces prior to sun exposure.

☐ **Bug spray** – Insect repellent 25% deet. Cover exposed skin and/or clothing as needed.

☐ **Benadryl Elixir** – 12.5 mg per 5 ml; weight dosage according to package, give PO/PT TID PRN for rash or persistent itch. MDD 3 doses.

☐ **Caladryl/Benadryl Lotion** – Apply sparingly to affected area of bug bite, rash, or minor skin irritation TID PRN.

☐ NO STANDING ORDERS ARE PRESCRIBED

MEDICATION ORDERS

How does the camper take medications? ☐ Crushed ☐ Swallows whole

Medication Name / Strength	Amount	Route	Frequency	Hour	Purpose	Prescribing Physician

Authorization: I do hereby grant permission for the camp healthcare providers to follow the above medication orders.

Physician Signature **Physician Name** **Date**