easterseals
Central & Southeast Ohio

SUMMER DAY CAMP

2024 CAMP DETAILS

6 weeks, June 17th—July 26th

Monday-Friday 9 a.m.—3 p.m.

Easterseals Central & Southeast Ohio
3830 Trueman Court
Hilliard, Ohio 43026

WANT TO KNOW MORE?

Contact Lisa McCarty: 614-228-5523
Lmccarty@easterseals-cseohio.org
www.eastersealscentralohio.org

Enrollment packets available by email and/or USPS

Space is Limited

Easterseals Summer Camp offers a fun recreational experience for children with and without special needs! Our 6 week program is open to children who range in ages from 3-14 at the time of registration.

Nutritious morning and afternoon snacks are provided in the camp tuition. Families are responsible for providing a sack lunch everyday for their camper as well as transportation to and from camp each day.

Staff to student ratios are 1:4 for our campers. We are unable to accommodate campers requiring a one on one aide.

2024 Full Day Tuition Rate:

$2,100 for all age groups

Please Note:

•Cost for the center based camp may vary depending on your child's needs

- **A $30 non-refundable application fee is due at time of application submission.**

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Table of Contents

All forms are required for each participant unless otherwise noted below. Please refer to the table of contents to identify if a form must be completed for your participant's enrollment packet. Some forms are not required based on age, medication needs, and other factors.

	Registration Form
	Student Release Authorization
	Supervision Form
	Publicity Release
	Developmental History (3 pages)
	Payment Agreement
	Payment Authorization
	JFS 01234
	Other Applicable Jobs and Family Services Forms

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Registration Form

Full Name of Participant: _____

Date of Birth: _____

Sex: _____

Address: _____

Who does the child live with: _____

Name: _____

Relationship to child: _____

Phone: _____

Email Address: _____

Who is the legal guardian, if different from above?

Name: _____

Relationship to child: _____

Phone: _____

Email Address: _____

Summer Camp Program (please chose one)

	Young School Age (ages 5-7)
	Middle School Age (ages 8-10)
	Teenage School Age (11-14)

Diagnosis/Disability: _____

Please list anything else that would enable us to provide exceptional care for your child, including any special needs or accommodations they might need at camp:

_____

_____

_____

_____

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Student Release Authorization

The following individuals are authorized to pick up my child, _____, or be contacted in an emergency, when EasterSeals staff are unable to contact an authorized parent/guardian.

If authorized parent/guardian cannot be contacted, please contact the following individuals:

	Name	Cell Phone	Work Phone
1.			
2.			
3.			
4.			

Do NOT allow the following individuals to pick up my child:

1._____

2. _____

3. _____

Parent Signature: _____ Date: _____

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Supervision Form

Please review the levels of supervision below.

Level 1 One-on-One Supervision:	My child requires a designated staff person. Please note that Easterseals is unable to provide one-on-one supervision.
Level 2 Constant Supervision:	My child requires strict guidance but does not require a designated staff person throughout the day. They require full help with daily toileting and routines.
Level 3 Moderate Supervision:	My child can work with others but will require guidance to complete most activities. They may need more help with toileting and routines but can do some of it independently.
Level 4 Safety Supervision:	My child prefers to do things independently. They simply need a friendly face to watch over them throughout the day. They do not need help with toileting

Please note that we are only able to enroll children that fall within the levels specified below:

Young School Age Ages 5-7 (Level 2, Level 3, or Level 4)

Middle School Age Ages 8-10 (Level 2, Level 3, or Level 4)

Teenage School Age Ages 11-14 (Level 4)

Please circle which level of supervision your child will need

Level 1 Level 2 Level 3 Level 4

Childs Name: _____ Parent Signature: _____ Date: _____

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Publicity/Photo Release

I am the parent or legal guardian of _____, a child under the age of 18 years old. I understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of my child made my Easterseals, or its respective employees and agents may be used by Easterseals and those acting with its permission, for illustration, broadcast, or testimonial shared with the public in connection with the work of Easterseals. I assign Easterseals all my child's rights to these materials.

I understand that these materials made by Easterseals, its employees and agents are owned by Easterseals and that they may copyright them. I further consent to allow Easterseals, their respective employees, agents, and those acting with Easterseals' permission, to use my child's protected health information, as defined under 45 C.F.R. 164.201 for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals and to release this information to the public. I understand that these materials may be published on Easterseals' network of web sites, and this may disclose my child's personal and protected health information online. However, Easterseals' online disclosures of my child's name and residence will be limited to my child's first name and the geographic location of the Easterseals' organization where he or she receives services. Easterseals does not need to submit these materials to me for further approval. I understand that these materials may be modified, and that Easterseals may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals will not condition any treatment or funding to my child on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals to release my child's protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Central and Southeast Ohio Inc. in writing. I understand and agree that once Easterseals, its respective employees, agents, and those acting with its permission, disclose my child's protected health information, the Health Insurance Portability and Accountability Act of 1996 may no longer protect this information. This release and authorization expires 10 years from the date of my signature below.

_____ I have read this release and authorization before signing below, and I fully understand and AGREE to its contents

_____ I have read this release and authorization before signing below, and I fully understand and DO NOT AGREE to its contents

_____ I have read this release and authorization before signing below, and I fully understand and AGREE my child's photo may be taken for summer scrapbooks and my child may be in photos in other children's scrapbooks.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

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Developmental History (page 1 of 3)

Please complete the following pages to help us learn more about your camper. This information allows us to help them have their best camp experience. Please be sure to include any additional information that might be helpful for us to know

Does your child have any of the following adaptive medical needs?	
☐ Glasses	☐ Hearing Aid
☐ Leg Braces	☐ Wheelchair
☐ Feeding Tube	☐ Catheter
☐ Communication Devices	☐ Cochlear Implant
☐ Walker	☐ Specialized Seating
☐ Orthotics	☐ Shunt

Has your child had any the following?	Yes or No	If yes, please explain
Seizures (with or without fever)		
Head Trauma		
Speech Problems		
Tics or repeated movements		
Behavior problems		
Weight Loss/Gain/ Trouble with appetite		
Sensitivity to lights, smells, sounds, or tastes		
Vision Problems		
Hearing Problems		
Heart Problems		
Hay Fever/ Asthma / Allergies		
Lung Problems		
Diarrhea/ Constipation / Stomach Problems		
Trouble touching certain textures		
Kidney Problems / UTIs		
Immune System Problems		
Broken Bones or Joint Problems		
Skin Problems		
Endocrine Problems		
Scarlet Fever		
Pneumonia		
Treatment for Tuberculosis		
Chicken Pox		
Measles / Mumps		
Meningitis		
Clostridium Difficle (C-Diff) positive		
Cytomegalovirus (CMV) positive		
Other:		

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Developmental History (page 2 of 3)

Please list any information that you think might be helpful for us to know about your child. You may use the back of this sheet for additional writing space.

Personality:	
Special Talents:	
Interests/Hobbies/Favorites:	
Other Important things to know:	
Reinforcers:	
Dislikes:	

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Developmental History (page 3 of 3)

Additional Information:

How closely does your child need to be supervised throughout the day?

_____

_____

Does your child exhibit any behaviors (tantrums, aggressiveness, self-injury, etc.) that staff should be aware of?

_____

_____

How would you describe your child's verbal skills?

_____

_____

Is your child ambulatory?

_____

Does your child wet the bed during naptime?

_____

After toileting, does your child need help with personal hygiene?

_____

Please indicate if your child has any of the following. If so, please include a copy upon submission of the application.

☐(IFSP) Individual Family Service Plan

☐ (IEP) Individualized Education Plan

☐ Behavioral Plan

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Payment Agreement

Tuition: $2,100

Application Fee: $30

Please read the following agreement carefully before signing:

The conditions of this agreement are to provide protection for our children and parents/guardians as well as Easterseals. The center's salaries and overhead cannot be reduced because of the absentee losses of income. This agreement is a parent/guardian guarantee to Easterseals that you are financially responsible for the enrollment space guaranteed for your child.

Please check the applicable box below

☐ **Preschool Ages 3-5**

☐ **Young School Age Ages 5-7**

☐ **Middle School Age Ages 8-10**

☐ **Teenage School Age Ages 11-14**

Please check the requested payment option below

☐ **In full by June 14th, 2024**

☐ **Half on June 14th, 2024, and half on July 8th, 2024**

Payments may be made in the form of cash, money order, credit/debit card or a check made payable to Easterseals. There will be a fee of $50 on returned checks. Easterseals reserves the right to request that future payments be made in cash or money order.

- There are no deductions for absence including illness, family vacation, and holidays for which the center is closed. Your child may be dropped from the program for nonpayment.
- There will be an additional charge if you are late picking up your child. Withing the first 15 minutes, the charge is $10. Each minute thereafter will be $1, up to 30 minutes. If we have not heard from the family and Easterseals has exhausted attempts to contract persons on the Emergency Contacts Form, your child will be taken to Franklin County Children's Services.
- This agreement is subject to change by Easterseals.
- I understand that if I do not provide a payment authorization form that it will be my responsibility to ensure that payment is received. Any late payments are subject to a late payment fee.

Payment of 25% of the tuition must be submitted by April 19th , 2024 to guarantee your child's spot in the program.

Childs Name: _____ Parent Signature: _____ Date: _____

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Payment Authorization

Name on Card: _____

Billing Address: _____

Card Number: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Expiration Date: _ _ / _ _ _ _

CVV Code: _ _ _

Please initial the requested payment plan

__ In Full

__ Half & Half

By signing this agreement, I give EasterSeals permission to authorize the method of payment provided on this form for all applicable charges related to the payment plan chosen above.

Childs Name: _____ Parent Signature: _____ Date: _____

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Ohio Department of Jobs and Family Services Documents

This program is licensed through the Ohio Department of Jobs and Family Services. As such, we are required to obtain the following forms. Should you have any questions regarding which forms are required for your child, please do not hesitate to reach out. Since JFS 01234 is required for all participants, it is included in this application.

JFS 01234 – Child Enrollment and Health Information for Child Care (4 pages) – Required for ALL participants.

JFS 01217 – Request for Administration of Medication (3 pages) – Only required if medication is needed that is NOT related to a diagnosis (example: cough syrup for a cold)

JFS 01236 – Child Medical / Physical Care Plan for Child Care (4 pages) – Required for each medical condition/diagnosis (example: If your child has allergies, cerebral palsy, and epilepsy, **three** completed care plans will be required; one for allergies, one for cerebral palsy, and one for epilepsy. The applicable medications for each can be put on these forms)

Please note that if your child attended camp last year and all the applicable information is the same, please advise the School Age Programs Manager upon submission of your application. You will need to review the applicable form(s) for accuracy and initial the form(s). Please note that if ANY updates are needed, a new form will be required.

To obtain these forms, you can either advise SAPM of the forms required (and I will either email/mail you the applicable forms) or you may type the form number (JFS 01236, JFS 01217) into Google/Safari, and you will find a link to a PDF fill-in option on the Ohio Department of Jobs and Family Services Website.

Please note that these forms must be completed and returned to the School Age Programs Manager prior to notice of enrollment to programming.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital	
Street Address	
City / State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation. ☐ Not applicable
List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted. ☐ Not applicable
List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits. ☐ Not applicable
List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs. ☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give ***Permission*** to Transport			***Do Not Give Permission*** to Transport	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**OR** **Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication