Step #1

EASTER SEALS CAMP FAIRLEE

Easter Seals Delaware and Maryland's Eastern Shore
22242 Bay Shore Rd. Chestertown, MD 21620
Voice 410-778-0566 Fax 410-778-0567
Email: Fairlee@esdel.org Web: www.de.easterseals.com/fairlee

RESPITE WEEKEND APPLICATION FORM

Participant Information (Please print clearly or type)

First Name | Last Name | ☐**New Participant** ☐**Returning Participant**

Address

City | State | Zip | County

Birthdate | Age

Male/Female | Height | Weight

Ethnic Origin (Optional-please check one) ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Native American ☐Other

☐ Parent ☐ Guardian ☐ Care Provider Information (Please check one)

Name

Home Phone | Cell Phone | Work Phone

Email Address:

Emergency Contacts

Name | Relationship

Home Phone | Cell Phone | Work Phone

Name | Relationship

Home Phone | Cell Phone | Work Phone

2016-2017 Respite Weekend Dates

Please select session(s) the participant wishes to attend. Slots are available on a first come first served basis.

☐ September 23-25, 2016	Youth/Adult	All ages	25 openings
☐ October 14-16, 2016	Autism	All ages	25 openings
☐ October 28-30, 2016	Multiple Sclerosis	All ages	25 openings
☐ December 9-11, 2016	Youth/Adult	All ages	25 openings
☐ December 16-18 , 2016	Autism	All ages	25 openings
☐ February 17-19 , 2017	Youth/Adult	All ages	25 openings
☐ February 21-24, 2017	Youth/Adult	All ages	25 openings
☐ March 17-19, 2017	Youth/Adult	All ages	25 openings
☐ March 31-April2, 2017	Autism/1:1	All ages	12 Openings
☐ May 5-7, 2017	Multiple Sclerosis		25 Openings

The **fees** for respite weekends: **3:1** supervision is **$475.00 2:1** supervision **$550.00**. Participants requiring **1:1** supervision the fee is **$700.00**. **(Each weekend will have available 1:1 openings you must call for approval before registering.)** Acceptance is based upon staff availability.

Participants that use Maryland Autism Waiver Program will need 30 hours per weekend added to their Plan of Care. (You must contact your Service Coordinator and have the Plan of Care submitted to Camp prior to coming.) The Plan can be faxed or emailed to camp separate from the registration.

Referral Information ***Please complete….even if you are a returning participant.***

Name of Teacher/Caseworker/Coordinator:

Agency:

Address:

Phone:

PAYMENT INFORMATION AND OPTIONS. Please check all that apply. This section must be completed and signed.

_____ Choice 1: Full Payment Enclosed

_____ Choice 2: $50 deposit enclosed

_____ Choice 3: Paying by credit card. (Visa, MasterCard, Discover, and American Express) Please call with card information.

_____ Choice 4: Paying balance monthly. (Must be confirmed with Administration and Director)

_____ Choice 5: Autism Waiver (A copy of your Plan of Care must be submitted to Camp with the number of hours needed.)

Amount Enclosed $_____ Balance left to be paid $_____

Signature of individual responsible for payments/balance _____

We encourage you to contact clubs, businesses, organizations and agencies for funding assistance. Please note: If a funding source is paying your deposit and or balance, a completed **Letter of Intent must be on file**.

_____ Choice 6: Balance to be paid by an agency or organization. (Please complete information below.) **$**_____

_____ Choice 7: Deposit and balance to be paid by an agency or organization. (Please complete information below.) **$**_____

Agency/Organization Name_____ Contact Name_____

Address_____

City_____ State_____ Zip Code_____ Phone_____

WAIVER AND RELEASE (Applications will not be accepted without a signature.)

This document must be signed by either the parent or legal guardian if applicable. All references to the participant include the parent or legal guardian.

As a condition of participation in the summer camp program, the participant agrees to the following:

Participant acknowledges that a wide variety of activities will be conducted, including swimming. Participant acknowledges that some of the activities may subject him/her to certain stresses and hazards not all of which can be foreseen. Participant desires and consents to take part in all such activities unless otherwise indicated in writing prior to the summer camp program. Participant assumes all the risks incident to the nature of the activities to be conducted and agrees that neither Easter Seals Delaware and Maryland's Eastern Shore, nor any of its representatives shall be held responsible for any damages or injuries resulting to the participant in the program. In the event the program staff determine that the participant cannot meet the program eligibility requirements the participant may be dismissed. Supervision and transportation resulting from dismissal of such participant are the responsibility of the participant.

Participant understands that Easter Seals and its representatives are not responsible for loss or damage to the personal property and possessions of the participant.

Participant is liable for any damage to the property of Easter Seals resulting from the acts of the participant.

Participant consents to the use of any film/photographs/video taken during the program, whether for advertising, promotion and/or publicity purposes by Easter Seals unless otherwise indicated in writing prior to the program. The participant waives all claims of compensation for such use.

Permission is granted for participant to attend all program field trips, participant acknowledges that transportation may be provided for program related purposes in a vehicle provide by Easter Seals and its representatives. It is the participants responsibility to adhere to all safety requirements (using seat belts and remaining seated).

Participant represents that all of the information provided in this application, including the health forms, is true and correct and that Easter Seals and its representatives have full right and authority to rely on the information contained therein. Participant further recognizes that Easter Seals and its representatives reserve the right to reject any participant in the event of the failure or refusal of the participant to accurately complete and sign all of the required documents.

I have read and fully understand the program details, waiver and release.

_____

Signature of Parent/Guardian **Date**

_____

Ratio Descriptions

3:1 Ratio

This ratio applies to participant who need minimal, occasional or no assistance from staff, such as verbal prompts, reminders, or gestures during their daily camp schedule. Participants must be ambulatory and can walk independently or use a wheelchair and can transfer independently or with minimal assistance. Participants must also follow directions of their assigned staff on a regular basis, participate in activities on a regular basis with no disruptive behaviors and sleep at night in a group setting.

2:1 Ratio

This ratio applies to the participant who needs close supervision and regular assistance such as verbal prompts, reminders, gestures, schedules, hand over hand assistance during their daily schedule as well as meals and morning/night routines. Participants can be ambulatory or use a wheelchair and bear weight or need assistance from the staff such as a 1 or 2 person transfer. Participants must be able to follow direction or can be redirected easily by staff, participate in activities on a regular basis with no disruptive behaviors and sleep at night in a group setting.

1:1 Ratio

This ratio applies to participant who needs constant supervision and individual assistance such as verbal prompts, reminders, gestures, schedules, hand over hand assistance during their daily schedule as well as meals and morning/night routines. Participants can be ambulatory or use a wheelchair and bear weight or need full assistance from the staff such as a 1 , 2 ,3 person transfer or hoyer lift. This also applies to the participant that has a history or current history of disruptive behaviors such as aggression to self or others, elopement, non-compliance, inappropriateness, sleeping issues or any behavior that could be considered disruptive to self or others. Or participants that do not attend planned camp activities on a regular basis, or require hourly health services, such as tube feedings, overnight tube feedings or other health treatments that must be given by a nurse periodically throughout the day.

LETTER OF INTENT FOR FUNDING

for

Easter Seals Camp Fairlee

By completing this, your organization, agency, or group has agreed to provide funding for the participant named below, who will be attending Easter Seals Camp Fairlee during the time frame listed below.

Organizations, agencies, and groups such as yours, are vital in helping people with various disabilities enjoy the independence that a summer camping experience can provide. If you require any further information, please do not hesitate to contact us directly.

If you are using the Autism Waiver you **do not** need to complete this form.

Please make sure this form is filled out completely. Mail or fax as soon as possible to our **Administrative Assistant** at: Camp Fairlee, 22242 Bay Shore Rd., Chestertown, MD 21620. Phone: (410) 778-0566. Fax: (410) 778-0567. Our Federal ID number is 51-0066728.

Participant Name _____

Address _____

Camp Session Date/s _____

Amount of Funding Requested $_____

This section <u>must be completed</u> and signed by the Organization/Agency/Group authorizing payment.

The following Organization, Agency or Group has agreed to provide funding in the amount of **$** _____ for the above participant who will be attending Easter Seals Camp Fairlee.

Organization/Agency/Group Name: _____

Organization/Agency/Group Contact: _____

Organization/Agency/Group Address: _____

_____

Organization/Agency/Group Phone: _____

Signature of Authorizing Contact: _____

☐ Payment Enclosed ☐ Please send invoice to Organization at the above address.

Checks can be made payable to: **Easter Seals Camp Fairlee**

On behalf of the people we serve, Camp Fairlee thanks you for your support.

easterseals Camp Fairlee

Easter Seals Camp Fairlee

PARTICIPANT INFORMATION

Participant Information (Please print clearly or type.)

Name	Last Name	Nickname

Disability Information: Please **check** the **primary** and underline all that apply.

- ☐ Speech-Language
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Peripheral Nerve Injury/Disorder
- ☐ Muscular Dystrophy
- ☐ Central Nervous System Injury/Disorder
  - ☐ Stroke
  - ☐ Epilepsy/Seizure Disorder
  - ☐ Multiple Sclerosis
  - ☐ Head Injury
  - ☐ Spinal Cord Injury
- ☐ Neurological Condition(s) at Birth
  - ☐ Cerebral Palsy
  - ☐ Down Syndrome
  - ☐ Spina Bifida
- ☐ Social/Psychological
  - ☐ Autism
  - ☐ Behavior
  - ☐ Alcohol/Drug Disorders
  - ☐ Psychosis
- ☐ Learning/Developmental Delay
- ☐ Mental Retardation

Level: ☐ Mild ☐ Moderate ☐ Severe/Profound

- ☐ Attention Deficit Disorder
- ☐ Orthopedic Impairments at Birth
- ☐ Postural Disorders
- ☐ Heart, Circulatory, Respiratory
- ☐ Asthma
- ☐ Skin and Cellular Tissue Disorder
- ☐ Allergic/Metabolic/Nutritional
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Geriatric Aging
- ☐ Other Disabilities (please list)

_____

General Background: Please check all that apply.

Communication

- ☐ Speaks Clearly
- ☐ Uses Sign Language
- ☐ Speaks may difficult to understand
- ☐ Uses communication board
- ☐ Gestures
- ☐ Other: _____

Language Spoken/Understood_____

Vision

☐ Normal ☐ Mild/Moderate Loss

☐ Severe/Total Loss

Does participant wear corrective lenses? ☐ Y ☐ N

Hearing

☐ Normal ☐ Mild/Moderate Loss

☐ Severe/Total Loss

Does participant wear hearing aids? ☐ Y ☐ N

Mobility

- ☐ Walks independently
- ☐ Walks with assistance
- ☐ Walks with cane/crutches/walker
- ☐ Walking ability affected, but walks independently
- ☐ Uses Wheelchair
  - ☐ Manual ☐ Power
- ☐ Uses AFO"S

Personal Care Please check all that apply, and provide a complete description if participant requires assistance.

Task	Independent	Requires Some Assistance	Requires TOTAL Assistance	Description of Assistance Needed
Dressing				
Showering				
Teeth Brushing				
Shaving				
Transferring				
Menstruation				

Staff Support	☐ **1:1**	☐ **2:1**	☐ **3:1**	
Bathroom Assistance Needed	☐ No Assistance	☐ Partial Assistance	☐ Total Assistance	
Aids Used (check all that apply)	☐ Diapers	☐ Bedpan	☐ Urinal	☐ Toilet Chair
Bladder Control	☐ Normal	☐ Has Accidents	☐ Incontinent	☐ Wets bed
Bowel Control	☐ Normal	☐ Has Accidents	☐ Incontinent	☐ Colostomy
Eating Assistance	☐ No Assistance	☐ Partial Assistance	☐ Total Assistance	☐ Can feed self finger foods

What adaptive devices are used for eating? (must be sent to camp)_____

Does participant have difficulties swallowing: ☐ Solids ☐ Liquids ☐ or Uses a Straw

Does participant have any known food allergies or problems with foods?_____

Additional Information

Has the participant previously attended a residential camp? ☐ Yes ☐ No
If Yes, what Camp: _____

If Yes, was it a positive experience? ☐ Yes ☐ No
If No, please explain: _____
_____
_____

Does the participant follow direction? ☐ Yes ☐ No ☐ Occasionally
If No or Occasionally, please explain: _____
_____

Does the participant have any behaviors of which the staff need to be aware? ☐ Yes ☐ No
If Yes, please explain:_____
_____

Are there key actions, words, or phrases used to stop behavior and redirect? ☐ Yes ☐ No
If Yes, please explain: _____
_____

Is a behavior management plan currently being used with the participant? ☐ Yes ☐ No
If Yes, please send a copy with the application. Easter Seals prohibits most restrictive behavior intervention techniques. Acceptance will be based on our ability to follow plans within agency policies.

Does the participant sleep through the night? ☐ Yes ☐ No
If No, please explain: _____
_____

Please list any strong fears the participant may have: _____
_____

Please list any activities the participant especially dislikes: _____
_____
_____

Please list any activities the participant especially enjoys: _____
_____

Please use this space for any other information you feel would be helpful in providing the best experience for the participant._____
_____
_____
_____
_____