



# 2016 Summer Respite Camps Application

(Wil-O-Way Underwood, Wil-O-Way Grant and Schuetze Rec Center)

\*\*\*All areas must be filled out in order for applications to be processed.\*\*\*

**Has applicant ever attended an Easter Seals Camp?**  Yes  No *\*If no, an Easter Seals Respite Supervisor will contact you after receiving your application to set up a new camper assessment.*

**List any dates you will not be attending camp, especially over the week of the 4<sup>th</sup> of July** (This information will help us to staff the camps appropriately over the course of the summer): \_\_\_\_\_

Camper's Name: \_\_\_\_\_

Gender:  Male  Female      Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Age at time of program: \_\_\_\_\_ (if over 21, may be waitlisted)  
Height: \_\_\_\_\_' \_\_\_\_\_"      Weight: \_\_\_\_\_ lbs.

**Disability** (check all that apply):  Learning Disability       Physical Disability      **Heritage:**  Hispanic  
 Autism       Speech/Language       African American       Native American  
 Down Syndrome       Emotional Disability       Asian       Other: \_\_\_\_\_  
 Cerebral Palsy       Rett Syndrome       Caucasian  
 Attention Deficit Disorder       Other: \_\_\_\_\_  
 Cognitive Disability  
 Hearing Impairment

**Degree of Disability:**  Mild     Moderate     Severe      **Household Income:**  \$0-\$20,000  
Please check appropriate family annual income.       \$20,001-\$29,000  
This will assist our agency in providing feedback to our funding sources.       \$30,000-\$39,999  
 \$40,000-\$49,999  
 \$50,000-\$59,999  
 More than \$60,000

**Physical Limitation:**  Sight       Speech  
 Ambulation       Spasticity  
 Hearing       None  
 Prosthesis

**Shirt Size** (50% Cotton/50% Polyester):  
Child:  6/8     10/12     14/16  
Adult:  Sm     Med     Lg     XL     2XL     3XL  
 I would like an extra T-shirt for an additional \$10

**Are any members of the camper's immediate family on active duty for any branch of the military** (including the National Guard and Reserve): Yes:  No:

# of People in Your Family: 1 2 3 4 5 6 6+      Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Caregiver Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

(If Different From Above)

Emergency Contact Phone(s): \_\_\_\_\_

Alternate Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Alternate Emergency Contact Phone(s): \_\_\_\_\_

During the school year, the camper is:  Home     School     Work     Day Program  
Specify: \_\_\_\_\_

**Bus Transportation:** *Must be the same every week unless there is an emergency. Both pick-up & drop-off locations must be filled out for transportation to be provided. Transportation is provided for Wil-O-Way campers only.*

Request Bus Transportation:  Yes     No, I will provide my own transportation

Request Wheelchair Accessible Bus:  Yes     No

Request Harness:  Yes     No (we must have authorization to use harness on bus)

Does participant use his/her own house key?  Yes     No

At the time of drop-off, can the participant remain alone?  Yes     No *\*If the AM pick-up location and/or PM drop-off location will be different than the address you listed above, please fill out the information below.*

AM Pick-Up Location: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Person at AM Pick-Up Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PM Drop-Off Location: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Person at PM Drop-Off Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**How did you hear about us?**

Brochure     Resource Fair     Website     Word-of-Mouth     Facebook/Twitter     Other: \_\_\_\_\_

REQUIRED FOR WIL-O-WAY GRANT, UNDERWOOD OR SCHUETZE SUMMER RESPITE



# 2016 Camp Sunburst Application

(Adults ages 22-70 - June 13-17, 2016)

\*\*\*All areas must be filled out in order for applications to be processed.\*\*\*

\*You are required to commit to the entire week.\*

Has applicant ever attended an Easter Seals Camp?  Yes  No

Camper's Name: \_\_\_\_\_

Gender:  Male  Female      Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Age at time of program: \_\_\_\_\_  
Height: \_\_\_\_\_' \_\_\_\_\_"      Weight: \_\_\_\_\_ lbs.

Disability (check all that apply):  Learning Disability      Heritage:  Hispanic  
 Autism       Physical Disability       African American       Native American  
 Down Syndrome       Speech/Language       Asian       Other: \_\_\_\_\_  
 Cerebral Palsy       Emotional Disability       Caucasian  
 Attention Deficit Disorder       Rett Syndrome  
 Cognitive Disability       Other: \_\_\_\_\_  
 Hearing Impairment

Degree of Disability:  Mild     Moderate     Severe  
Physical Limitation:  Sight      Household Income:  \$0-\$11,999  
 Ambulation       Speech      Please check  \$12,000-\$14,999  
 Hearing       Spasticity      appropriate family  \$15,000-\$24,999  
 Prosthesis       None      annual income. This  \$25,000-\$49,999  
will assist our agency in  \$50,000-\$74,999  
providing feedback to  More than \$75,000  
our funding sources.

Shirt Size (50% Cotton/50% Polyester):  
Child:  6/8     10/12     14/16  
Adult:  Sm     Med     Lg     XL     2XL     3XL  
 I would like an extra T-shirt for an additional \$10

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Caregiver Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(If Different From Above)

Emergency Contact Phone(s): \_\_\_\_\_

Alternate Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Alternate Emergency Contact Phone(s): \_\_\_\_\_

During the school year, the camper is:  Home     School     Work     Day Program  
Specify: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Care Management Agency: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

You are responsible for your own transportation:  
AM Transportation Company \_\_\_\_\_ Phone #: \_\_\_\_\_  
PM Transportation Company \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us?  
 Brochure     Resource Fair     Website     Word-of-mouth     Facebook/Twitter     Other: \_\_\_\_\_

REQUIRED FOR CAMP SUNBURST (AGES 22-70)



# 2016 Behavior Information

Please attach one recent photo (2" x 3") It will be used for participant identification

Camper's Name: \_\_\_\_\_  
First Middle Last Nickname

**Please check all that are appropriate (to better serve the participant):**

In the comments section below, for each item checked, please describe triggers, what the behavior(s) look like - typical duration, frequency and intensity - as well as any tips to help our staff decrease the behavior(s) and/or avoid the behavior(s). Be as descriptive as possible, so that we can do all we can to make sure campers remain successful at camp.

- Generally Easy-Going/Happy
- Shy/Withdrawn
- Unsure of New Situations
- Helpful
- Verbally Aggressive/Demanding
- Physically Aggressive
- Wanders/Needs Continuous Direction
- Other: \_\_\_\_\_

**Comments:**

Describe camper on their best day:

Describe camper on their worst day:

**Please check all the activities the camper enjoys:**

- Arts & Crafts
- Basketball
- Baseball
- Board Games
- Bowling
- Cookouts
- Dancing
- Fishing
- Gardening
- Movies
- Music
- Nature Hikes
- Sports & Games
- Swimming
- Volleyball
- Other: \_\_\_\_\_

**Are there any activities that should be specifically excluded?**  Yes  No

If yes, please specify: \_\_\_\_\_

**Does the participant have any fears?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Describe the best way(s) to engage participant:**

**Please write any other information you feel our staff would benefit from knowing: PLEASE BE AS DESCRIPTIVE AS POSSIBLE!**

**FOR TEACHERS AND/OR OTHER CAREGIVERS: Please write any other information you feel our staff would benefit from knowing: PLEASE BE AS DESCRIPTIVE AS POSSIBLE!**

REQUIRED FOR ALL CAMPS



# 2016 Care Information

Camper's Name: \_\_\_\_\_

REQUIRED FOR ALL CAMPS

**Vision:**

- Sighted  Partial Sight  Night Blindness
- Legally Blind  Color Blind

**Hearing:**

- Normal  Normal with Aid  Partial Loss
- Partial with Aid  Legally Deaf

**Communication:**

- Verbal  Non-Verbal  Gestures
- Communication Board
- Sign Language (please attach list of words)
- Other: \_\_\_\_\_

**Eating:**

- No Assist  Partial Assist  Total Assist

Explain Partial: \_\_\_\_\_

List Adaptive Equipment Used:

\_\_\_\_\_

- Time to eat:  10 min.  20 min.  30 min.
- 40 min.  50 min.

G-Tube Feeding: \_\_\_\_\_

Dosage: \_\_\_\_\_

Schedule: \_\_\_\_\_

**Diet:**

- Standard  Blended/Pureed
- Chopped Food  Low Calorie  Low Salt
- No Sugar  Other: \_\_\_\_\_

**Mobility:**

- Ambulatory  Braces  Cane  Crutches
- Scooter  Walker  Wheelchair
- Motorized Wheelchair Assistance needed with mobility:
  - None  Partial  Total

Assistance needed with mobility at camp:

- None  Partial  Total

Do you need a wheelchair for long distances such as field trips?  Yes  No

Are you able to provide a wheelchair for use on field trip days if needed?  Yes  No

**Transfer:**

- No Assist  Transfer Type  Independent
- Standby  Stand Pivot  Two People
- Hoyer Lift  Other: \_\_\_\_\_

**Adaptive Devices:**

- None  Braces  Prosthesis  Helmet
- Glasses  Dentures  Shunt  Other: \_\_\_\_\_

**Toileting:**

- No Assist  Partial Assist  Total Assist

Schedule (please check designated times):

- 10:00  10:30  11:00  11:30  12:00  12:30
- 1:00  1:30  2:00  2:30

**Maintains Bladder Control:**

- Always  Sometimes  Never
- Needs Reminder

**Maintains Bowel Control:**

- Always  Sometimes  Never
- Needs Reminder

**Aids Used:**

- None  Urinal  Toilet Chair  Bedpan
- Diapers  Pull-Ups  G-Tube
- Catheter (Type: \_\_\_\_\_)

**Personal Hygiene:**

Washing Hands:

- No Assist  Some Assist  Total Assist
- Needs Reminder  Supervision

Dressing:

- No Assist  Some Assist  Total Assist
- Needs Reminder  Supervision

Menstrual Care:

- No Assist  Some Assist  Total Assist
- Needs Reminder  Supervision

**Allergies:**

- Animals: \_\_\_\_\_
- Environment: \_\_\_\_\_
- Food: \_\_\_\_\_
- Medicine: \_\_\_\_\_
- Sunscreen/Bug Spray: \_\_\_\_\_
- Other: \_\_\_\_\_

**Seizures:**

- None  Absence (Petit Mal)  Generalized Tonic
- Clonic (Grand Mal)  Non-Convulsive
- Nocturnal  Complex Partial (Psychomotor)
- Simple Partial  Myoclonic
- Atonic (Drop Attacks)  Mixed

Frequency:

List symptoms *before* seizure occurs: \_\_\_\_\_

\_\_\_\_\_

What does seizure look like? \_\_\_\_\_

\_\_\_\_\_

When should EMS be contacted? \_\_\_\_\_

\_\_\_\_\_



# 2016 Care Information *(continued)*

Camper's Name: \_\_\_\_\_

**If camper has Down Syndrome, has he/she been tested for Atlanto-Axial Instability?**  Yes  No  
Results Positive?  Yes  No

**Communicable Disease:**  Yes  No Specify: \_\_\_\_\_  
*If yes, this will not necessarily affect your enrollment. We need accurate information to plan for your safety and to maintain a safe and protective environment for all campers.*

**Medications: An up-to-date Medication Administration form MUST be on file for Easter Seals staff to administer any medication to campers. This form will be mailed out with your acceptance packet.**

Daily Medications (even if not administered at camp):  Yes  No

If yes, please specify: \_\_\_\_\_

Medications taken during camp:  Yes  No

Medications:	Dosage:	Time:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If you need to list more medications than the space provided, please attach an additional sheet.*

Permission to give camper over-the-counter medications:  Yes  No

If Yes, please specify:

Antacid  First Aid Cream  Ibuprofen  Tylenol  Other: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In the event of an emergency, please provide the following information so we can request the best care according to your wishes.**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Insurance Number: \_\_\_\_\_

Requested Hospital: \_\_\_\_\_

REQUIRED FOR ALL CAMPS



# 2016 Parent/Guardian Authorization

Camper's Name: \_\_\_\_\_

**Please read and check the appropriate boxes for each area.**

The Care Information is complete to my knowledge, and the applicant listed has permission to engage in all recreational activities and field trips, except as noted by me. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the respite supervisor, or by his/her designated staff, to secure proper treatment for applicant listed, including to hospitalize and/or to order injection, anesthesia or surgery only if I cannot be reached immediately.  
 Yes  No

I understand that Milwaukee County Office for Persons with Disabilities and Easter Seals Southeast Wisconsin are not responsible for lost, stolen or damaged personal articles brought to the camp sites. I understand that Easter Seals of Southeast Wisconsin is not responsible for injury to participants, while at summer camp programming.  
 Yes  No

I consent to the use of the applicant's name or any likeness of him/her including photographs, sketches, take and show films, as well as videotapes by the Milwaukee County Office for Persons with Disabilities and Easter Seals Southeast Wisconsin for any purpose deemed appropriate.  
 Yes  No

I consent that the applicant can use the following supervised pools at their campsite or on an outing. **These pools are pools at your preferred camp site or potential field trip locations.**  
 Wil-O-Way Grant/Underwood Wading Pool  
 Holler Park Pool  
 Buchner Pool, Waukesha  
 Cool Waters Aquatic Park, West Allis

I hereby give consent to Easter Seals Southeast Wisconsin staff to:

- Use cleansing tissues and/or powder or lotion when changing diapers  Yes  No
- Apply sunscreen/bug spray that is sent with camper on a daily basis  Yes  No
- Administer medications according to physician's instructions  Yes  No
- Perform special medical care (g-tube feeding, catheterization) as I have instructed  Yes  No
- Release or obtain written/verbal reports (educational, therapy, medical and/or psychological) containing information about my child  Yes  No

I hereby release and waive any claim or cause of action which may accrue against Milwaukee County Office for Persons with Disabilities, Easter Seals Southeast Wisconsin, any employee of listed agencies or any other person acting with the permission of either, arising out of any injury to their person or property during their stay at Easter Seals Summer Camp in transit or during any activity.

A signature indicates agreement of the above statement. Any applicant age 18 or older without a court appointed legal guardian must sign for him or herself.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED FOR ALL CAMPS



# 2016 Fee & Payment Information

Deadline May 13, 2016

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Guardian Address (if different than camper's): \_\_\_\_\_

Guardian Phone #: \_\_\_\_\_ Guardian E-mail: \_\_\_\_\_

Please make sure you are choosing the correct camp. Exact addresses for each camp can be found on pages 4-6 in the Camp Book. For more information about the changes to our camps, please see New for 2016 (Page 4).

**Summer Respite Camp: Campers ages 7-21 will be given preference.** If camps have openings after May 13th, campers over age 21 may be admitted. Transportation provided for Wil-O-Ways between 9:00 a.m. - 4:30 p.m.

1. Choose one camp. 2. Choose Session(s) & Fees(s). 3. Choose Extended Care (if needed).

<input type="checkbox"/> Wil-O Way Grant - South Milwaukee - <b>OR-</b>			<input type="checkbox"/> Schuetze Park - Waukesha (nine weeks)	
<input type="checkbox"/> Wil-O-Way Underwood - Wauwatosa				
Sessions (3 week sessions) 9:00am-4:30pm	Fees Milw. County Resident	Fees Non- Resident	Session & Extended Care June 20-August 19	Fees
<input type="checkbox"/> June 20 - July 8	<input type="checkbox"/> \$315	<input type="checkbox"/> \$470	<input type="checkbox"/> Full Day: 9:00am-4:30pm	<input type="checkbox"/> \$1800
<input type="checkbox"/> July 11-29	<input type="checkbox"/> \$315	<input type="checkbox"/> \$470	<input type="checkbox"/> AM Care: 7:30-9:00am	<input type="checkbox"/> \$675
<input type="checkbox"/> August 1-August 19	<input type="checkbox"/> \$600*	<input type="checkbox"/> \$600*	<input type="checkbox"/> PM Care: 4:30-6:00pm	<input type="checkbox"/> \$675
<b>Extended Care:</b> <input type="checkbox"/> AM Care: 7:30-9:00a \$225/session <input type="checkbox"/> PM Care: 4:30-6:00p \$225/session			<input type="checkbox"/> \$40 registration fee (53186, 53187, 53188, 53189) <input type="checkbox"/> \$140 registration fee (Non-resident)	

\*The funding provided by OPD does not cover the cost of Session 3. As a result, the cost of this option reflects the actual operating costs necessary for Easter Seals Southeast Wisconsin to provide staffing and transportation for each camper.

**Camp Sunburst Respite Camp: Open only to adults ages 22-70. Transportation is not provided.**

<input type="checkbox"/> Wil-O-Way Grant - South Milwaukee	<b>Fees Milw. County Resident</b>	<b>Fees Non Resident</b>
<input type="checkbox"/> Full Day: 9:00am-3:00pm	<input type="checkbox"/> \$200	<input type="checkbox"/> \$200
	<input type="checkbox"/> \$40 registration fee	<input type="checkbox"/> \$40 registration fee

Check here only if ordering a second t-shirt. The extra \$10 must be included with the application. Each camper is given one t-shirt for camp. You may choose to order a second one for an additional \$10.

<b>Total Fee:</b>	
Amount enclosed (\$100 deposit necessary for WOWs):	

Are you receiving Family Care funding? (If under age 18, does not apply)  Yes  No

Are you receiving funding for camp that we need to bill?  Yes  No

(If no, please fill out Private Pay Agreement on next page)

Name of Funding Source (e.g. IRIS, DHHS, etc.): \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**For IRIS:** I consent for Easter Seals to obtain the portion of my ISP that indicates Easter Seals is in my plan.

Yes  No Guardian Signature: \_\_\_\_\_

Please note all funding requests must be verified by Case Manager no later than May 13. If authorization is not received on time, your camper may be placed on a waitlist. **Sorry! There will be no proration of camp fees.**

REQUIRED FOR ALL CAMPS



# 2016 Private Pay Agreement

Applicant Name: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## FEES

In order to process your registration, your registration fee/deposit must be enclosed with this application. For the remainder of your balance, you may select one of the following payment options:

Method of Payment:  Bank Account  Credit Card

**The payment either by bank account draw or credit card will be transacted on May 13, 2016.**

### If paying by a draw from a Bank Account:

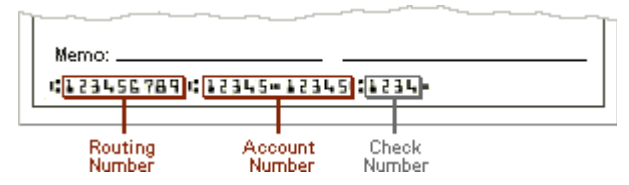
Bank Name: \_\_\_\_\_

Checking  Savings

Bank Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Please refer to the bottom line of your check to determine your Bank Routing Number and Account Number.



**Insufficient Funds:** Funds for this transaction must be available in your bank account May 13, 2016. If there are insufficient funds when your payment is processed, Easter Seals Southeast Wisconsin will charge a \$35 insufficient funds fee in addition to any applicable fees charged by your bank.

### If paying by Credit Card:

Name On Credit Card: \_\_\_\_\_ CVC #: \_\_\_\_\_  
*(three-digits on back of card)*

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

Billing Address: \_\_\_\_\_  
*Street Address City State Zip Code*

Cardholder Signature: \_\_\_\_\_

*Payments that are rejected by the bank or from the credit card company may result in termination from the program.*

## TERMINATION

In the event the participant's responsible party fails to meet any terms of this agreement or policies/procedures of the agency, which include failure to pay fees, Easter Seals reserves the right to terminate program participants. If a participant wishes to terminate his/her involvement in the program, 14 days written notice is required and refunds will be processed on the 15<sup>th</sup> and last day of the month.

## ADDITIONAL PROVISIONS

- This agreement is in effect and subject to the termination provision herein.
- The participant and responsible party agree to abide by such policies and procedures as may enact from time to time. Such policies and procedures shall be deemed a part of this agreement.
- Descriptions of services and policies are provided with the camp brochure.

I have read the Private Pay Agreement and hereby agree to the stated terms.

\_\_\_\_\_  
Signature of Applicant (if able to sign or mark) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian/Responsible Party \_\_\_\_\_  
Date

REQUIRED IF PAYING PRIVATELY