



CAMP TREASURE CHEST APPLICATION 2019

This form is to be completed and retained at the service delivery site.

For ages 6-21 only who are DDSN eligible!

\$60.00 application fee

I. PERSONAL INFORMATION

Applicant's Name _____

Address _____

Zip Code _____ Telephone#: _____

Date of Birth _____ Sex _____ Race _____ Medicaid #: _____

Parent/ Guardian's Name _____

T-Shirt Size: Youth or Adult XS S M L XL XXL XXXL

Emergency Contact _____

(If different from above)

Name

Telephone Number

I hereby authorize emergency medical care to be provided to my son/daughter in the event an emergency situation warrants such treatment.

Signature/Relationship

Date

Please describe special needs and/or physical limitations that your son/daughter has which should be brought to the attention of the Summer Services Program staff that would prevent his/her full participation in program activities:

II. **FAMILY SUPPORT NETWORK** Please list all family members residing in household:

Name	Relationship	Age	Employed (Circle one)	
			Yes	No

III. **ENTRANCE CRITERIA** - To be completed by a caregiver and case manager.

A. Intellectual range (AAMR)*

1. Mild (IQ 52-70)
2. Moderate (IQ 36-51)
3. Severe (IQ 21-35)
4. Profound (IQ 0-20)
5. Undetermined (attach enrollment justification if undetermined)

Date of Psychological _____

B. Accompanying Disability:

- | | |
|---------------------------|-----------------------------|
| 1. Autism | 8. Partial loss of vision |
| 2. Motor handicap | 9. Total loss of vision |
| 3. Cerebral Palsy | 10. Partial loss of hearing |
| 4. Seizure disorder | 11. Total loss of hearing |
| 5. Orthopedic handicap | 12. Major health problems |
| 6. Emotional handicap | 13. None |
| 7. Communication disorder | |

Describe special needs and/or limitations that would prevent this client's full participation in program activities:

C. Does your son/daughter require a shadow during the school year? ____yes ____no

If yes,
why? _____

IV. MEDICAL EVALUATION

This form is to be completed with appropriate signatures and is to be retained in the Camper's File at the service delivery site.

Camper information: Name _____
Program Camp Treasure Chest

Check Atypical only.

<input type="checkbox"/> Head & Face	<input type="checkbox"/> Spine & Neck
<input type="checkbox"/> Eyes, Vision	<input type="checkbox"/> Body Marks
<input type="checkbox"/> Nose	<input type="checkbox"/> Skin
<input type="checkbox"/> Mouth & Throat	<input type="checkbox"/> Lymphatic
<input type="checkbox"/> Neck	<input type="checkbox"/> Neurologic
<input type="checkbox"/> Ears, Hearing	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Thorax, Lungs & Breast	<input type="checkbox"/> Hernia
<input type="checkbox"/> Heart	<input type="checkbox"/> Anus/Rectum
<input type="checkbox"/> Vascular	<input type="checkbox"/> G.U. System
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Endocrine System
	<input type="checkbox"/> Extremities

COMMENTS: (Indicate special medical needs, physical limitations, and medications received)

Based upon my examination, this person appears to be able to participate in: (check one)

Physical Activities Not participate in Physical Activities

Physician's Signature Date Telephone Number

Street City State Zip Code

SEIZURES HISTORY Yes No (If yes, read and sign below)

I hereby permit my son/daughter to participate in waterfront, aquatic, and swimming activities with the knowledge that appropriate safety procedures have been established for campers who experience seizures.

Signature/Relationship Date