C.A.M.P. Program

Communicate, Articulate, Make friends & Play

Speech Language Pathology in Motion

2018 C.A.M.P. PROGRAM REGISTRATION FORM

Participant Name: _____ Date of application: _____

Participant DOB: _____ Age: _____ Grade for 2018-19 School year: _____

Address: _____

Home phone: _____ Cell Phone: _____

Names of individuals who will drop off or pick up participant other than parents. Child will only be released to parents and the individuals listed below:

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

Emergency contact information:

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

Does your child have any allergies and/or intolerances to food, medication or any other substances? What are the symptoms and action to be taken if any? _____

_____

Does your child have any medical conditions? If so, please list below: _____

_____

Is your child an active client at SLPIM? _____**Please note that spots are offered to active clients first. Others will be waitlisted until July 1st and accepted at that time if space allows. Individuals who are not active clients will need to attend a screening prior to acceptance to the program so we can ensure that we can meet the child's needs and can set appropriate goals.*

Has your child participated in the C.A.M.P. Program before? _____, If yes, when: _____

Does your child have any behavior difficulties? If so, please indicate here: _____

_____

Please briefly describe your child's communication difficulties/needs: _____

_____

_____

_____

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What would you like to see your child gain from participation in the C.A.M.P. Program? _____

_____

_____

_____

The 2018 C.A.M.P. Program is Aug 20-24, from 10:00 AM to 3:00 PM on the property of Pal-O-Mine Equestrian. Registration deadline is August 1st! Register by May 1st for a $100 discount!

Participants will be required to wear t-shirts daily. Two shirts are included with your registration. If you would like additional shirts they can be purchased for $12.00 each. Please indicate your size preference, and if you want additional shirts:

T-Shirt Size: Children's: Xs S M L XL or Adult: XS S M L XL Number of extra shirts requested: _____

_____ $1050.00 Full Day Early bird registration (until May 1st)

_____ $1150.00 Full Day Registration after May 1st (registration closes August 1st)

_____ $800.00 Modified/Half Day Early bird registration (until May 1st)

_____ $900.00 Modified/Half Day Registration after May 1st (registration closes August 1st)

_____ $12.00 per additional t-shirt

Total: _____

A $200 deposit is required with your registration to hold your spot at the program. Full balance is due by 8/1/18 and is non-refundable after that date.

I would like to pay by: _____ Check _____ Cash _____ Credit card: Please charge my card in the amount of _____

Cardholder Name: _____ Card Number: _____

Card Type: □ Visa □ MasterCard □ American Express □Discover

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Cardholder signature: _____ Date: _____

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Parent Statement of Understanding

Participant name: _____ DOB: _____

The following items are important for successful participation in the C.A.M.P. Program. Please read and initial each item.

_____ I understand that I am not to leave my child at the C.A.M.P Program site unless a staff member is there to receive and supervise my child.

_____ I understand that drop off is at 10:00 AM and pick up is at 3:00 PM.

_____ I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child must be listed on this form. Authorization by telephone will not be accepted.

_____ My child has permission to participate in all C.A.M.P Program activities including but not limited to swimming, horseback riding, arts & crafts, lunch, sports, playground and special events.

_____ I am aware that I must send the participant in with the following each day: C.A.M.P. Program t-shirt, pants, bathing suit, towel, sneakers, lunch, sunscreen/insect repellent (if desired), change of clothes, underwear/diapers, and swim diapers if needed. Water/pool shoes are recommended. All items must be labeled with the participants name.

_____ In the case that my child becomes ill during the program, I understand that I will be contacted as soon as possible. If the parent or guardian is unable to be reached, the emergency contact will be notified. It is the responsibility of the parents or guardians to arrange for the child to be picked up from the program as soon as possible.

_____ I understand that the program will take place rain or shine. SLPIM reserves the right to cancel or modify activities and locations due to inclement weather.

_____ I understand, if it is determined by SLPIM management that my child is unable to participate in the C.A.M.P. Program due to behavior difficulties or health reasons, that put the child or others at risk, that SLPIM reserves the right to dismiss my child from the program or modify my child's schedule to facilitate success. Refunds will not be given for modifications to the child's program or for dismissal from the program. Further, I understand that if I choose to remove my child from the program for any reason, my payment is non-refundable after the registration deadline.

_____ I authorize the management and staff of Speech Language Pathology in Motion to act for me according to their best judgment in the event of a medical emergency and/or routine medical care. I/we grant permission for emergency medical treatment and/or routine medical care by the C.A.M.P Program staff, a rescue squad, or private physician and/or hospital or emergency health care facility staff, under the same circumstances as above, if needed. Any such action will be taken in the best interest of my child and will be reported to me/us as soon as possible. I waive and/or release Speech Language Pathology in Motion, PLLC, it's management and staff and Pal-O-Mine Equestrian, it's members and staff from any and all liability and/or financial responsibility for any medical expenses incurred.

_____ _____ _____ _____

Signature Name Relationship to child Date

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Participant Information Sheet

The following information will be shared with the therapists, group leaders and 1:1 aides to help ensure that your child has a great week. Please fill it out to the best of your ability.

Participant name: _____

Bathroom: *If your child uses diapers/pull ups/wipes/swim diapers please send them in with your child.*

Child asks to use bathroom: yes/no. If yes, how do they indicate this: _____

_____

Does your child need help in the bathroom? Yes/no If yes, please indicate what type of assistance is needed:

_____

_____

Food/Drinks: *This must be sent in with your child*

Child indicates if they are hungry/thirsty: yes/no If yes, how do they indicate this: _____

_____

Does your child need assistance at meal times? Yes/no If yes, please indicate what type of assistance is needed:_____

_____

Dressing/changing: *Children will change before and after swimming*.

Does your child need assistance changing? Yes/no If yes, please indicate what type of assistance is needed:_____

_____

Please indicate a few things that are highly motivating or reinforcing for your child: _____

_____

_____

Is there anything else that you want the staff to know (i.e. apply sun screen, needs swim diapers, behaviors they should be aware of)? _____

_____

_____

Is your child allowed to have an ice pop provided by the program daily?

_____ Yes _____ No (I will send in an alternate snack)

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Emergency Medical Release

Notice to all Patients, Parents and Guardians
In many situations, a minor child or a dependent cannot receive emergency medical care without the authorization of a parent or guardian. This form must be completed.

Child/dependent's Name: _____

Pertinent Medical History:

_____

_____

_____

Medical Insurance Co.: _____ Policy No.: _____

Allergies: _____

Contact lenses (circle): Y or N

Date of last Tetanus Shot: _____

Medical Doctor: _____ Phone number: _____

If emergency medical care is required for my child/dependent and if I am not able to convey permission in a timely manner, then the undersigned authorizes appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or medical facility providing treatment.

Signature: _____ Date: _____

Print: _____ Relationship to patient: _____

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Media Release Form

Speech Language Pathology in Motion, PLLC occasionally uses client photos on marketing materials including brochures, business cards, the Speech Language Pathology in Motion website, our social media pages and in professional presentations. In addition, photos/video of the C.A.M.P. Program may be shared with family members of the participants. This will include a group photo.

By consenting below, I grant permission to Speech Language Pathology in Motion, PLLC and its representatives to take photographs or videos of the participant.

I further grant Speech Language Pathology in Motion, PLLC and their representatives the right to reproduce, use, exhibit, display, broadcast and distribute and create derivative works of these images and recordings in any media now known or later developed. I acknowledge that Speech Language Pathology in Motion, PLLC owns all rights to the images and recordings.

I waive any right to royalties or other compensation arising from or related to the use of the images, recordings, or materials. I hereby release, defend, indemnify and hold harmless Speech Language Pathology in Motion, PLLC from and against any claims, damages or liability arising from or related to the use of the images, recordings or materials, including but not limited to claims of defamation, invasion of privacy, or rights of publicity or copyright infringement, or any misuse, distortion, blurring, alteration, optical illusion or use in composite form that may occur or be produced in taking, processing, reduction or production of the finished product, its publication or distribution.

I have read this document before signing below, and I fully understand the contents, meaning and impact of this consent, waiver, indemnity and release. This consent, waiver, indemnity and release is binding on me, my heirs, executors, administrators and assigns.

Consent:

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

Non-Consent:

I understand that I have the right to decline that my child participates in media and/or photographs at the Speech Language Pathology in Motion C.A.M.P. Program.

Signature of Patient/Parent/Guardian: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

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Agreement & Release of Liability

Patient Name: _____ DOB: _____

I, _____ (Parent/Legal Guardian), hereby acknowledge that I have requested that my child participate in the Speech Language Pathology in Motion, PLLC, C.A.M.P. Speech and Language enrichment program. I am aware that this enrichment program will target speech and language skills during various activities including, but not limited to horseback riding, interactions with farm animals, arts & crafts, sports and games, swimming and water play, lunch and playground on the premises of Pal-O-Mine Equestrian Inc. under the care of Speech Language Pathology in Motion, PLLC. I agree to abide by all rules, written and implied, at Pal-O-Mine Equestrian Inc. and Speech Language Pathology in Motion, PLLC.

I am aware that participation in the C.A.M.P. Program involves inherent risks. In consideration for participation in the Speech Language Pathology in Motion, PLLC, C.A.M.P. program, on the property of Pal-O-Mine Equestrian Inc. I hereby agree that I, my heirs, my distributes, guardians, legal representatives and assignees will not make a claim against, sue, attach the property of or prosecute Speech Language Pathology in Motion, PLLC, it's directors, officers, members, employees, interns, volunteers or assignees, for any claim I now have or may hereafter have for death, injury or property damage resulting from participation in activities on the property of Pal-O-Mine Equestrian Inc. while under the care of Speech Language Pathology in Motion, PLLC, whether caused by my acts of omission or negligence or anyone else's acts of omission or negligence.

To the fullest extent permitted by law, I shall defend, indemnify and hold harmless, Speech Language Pathology in Motion, PLLC and its directors, officers, agents, volunteers, or employees for and against any and all claims, damages, losses, expenses and liabilities of any and every kind, including but not limited to attorney's fees, in any way arising out of or in connection with my activities under this agreement. This indemnity shall apply regardless of any active or passive negligent act or omission of Pal-O-Mine Equestrian Inc. and Speech Language Pathology in Motion, PLLC, its directors, officers, agents, volunteers and employees.

I agree that should emergency medical treatment be required, I/my medical insurance company shall pay for all such incurred expenses.

I have carefully read this agreement and release and fully understand its contents. I am aware that this is a release of liability, a waiver of legal rights and contract between me Speech Language Pathology in Motion, PLLC and I sign it of my own free will. I further acknowledge that there are no warranties, either expressed or implied, concerning the facilities, events or activities Speech Language Pathology in Motion, PLLC.

I, the undersigned, have read and do understand the foregoing agreement, warnings release and assumption of risk.

Please Print Clearly

Signature of Patient or Legal Guardian: _____ Date: _____

Please Print Name: _____ Relationship to participant: _____

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