The Arc of Essex County
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CAMP HOPE
A Program of The Arc of Essex County

Application for a Returning Camper

*A recent photo of your camper must be included with your application

Camper Name: _____ **Date Completed:** _____

Year that your camper last attended Camp Hope: _____

Have there been any changes in the areas below since last summer?

1.	**Communication**	**yes** ☐	**no** ☐
2.	**Physical Condition/Mobility**	**yes** ☐	**no** ☐
3.	**Toileting**	**yes** ☐	**no** ☐
4.	**Assistance with Feeding**	**yes** ☐	**no** ☐
5.	**Assistance with Dressing**	**yes** ☐	**no** ☐
6.	**Social/Emotional Development (behaviors, motivations, etc.)**	**yes** ☐	**no** ☐
7.	**New Assistive Devices** ** **(glasses, braces, orthotics, etc.)**	**yes** ☐	**no** ☐

**For all campers over the age of 21 a prescription is required for assistive devices. If the camper participates in another Arc of Essex County service, we will obtain that prescription from their program.

For any <u>yes</u> answers above, please provide details below or on the back of page.

_____

_____

_____

_____

_____

_____

_____

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Emergency Contacts
For New and Returning Campers

Emergency Contact Information (different than the Parent/Guardian listed on the Registration Form):

Emergency Contact #1

Name: _____ Relation to Camper: _____

Address: _____

Phone Number(s): _____

Emergency Contact #2

Name: _____ Relation to Camper: _____

Address: _____

Phone Number(s): _____

Transportation Release

To be completed for all campers that will be utilizing transportation provided by Camp Hope. A copy of this form will be given to the bus company.

Camper Pick-up/Drop-off Information

The following information will help determine the camper's bus pick-up/drop-off times. Addresses must be in Essex County.

Camper Name: _____

Please select one: Both AM and PM ☐ AM transport only ☐ PM transport only ☐

Address:

_____

(Street number) (Town) (Zip)

Phone number(s) of responsible person at pick-up/drop off: _____

Transportation Release

I, _____, hereby give The Arc of Essex County, Inc. ("The Arc"), Camp Hope ("Camp") and the Transportation Company (not owned/managed by The Arc of Essex County) permission to provide or arrange necessary related transportation for my child/family member.

I give consent for emergency transportation to a medical facility (by ambulance) for my family member. I also confirm that I have given the Camp and The Arc of Essex County a complete and accurate medical history of my child that may be shared with the contracted bus company.

Signature of Parent/Guardian: _____ Date: _____

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CAMP HOPE
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Camp Hope Photo Release

For New and Returning Campers

THE ARC OF ESSEX COUNTY

Photographs of campers may be taken and used for publicity purposes including but not limited to: publications in commercial periodicals; The Arc of Essex County newsletters and social media; The Arc of Essex County website; and various print, internet, and media publications of The Arc of Essex County.

Please check one:

_____ I give permission for my camper's photo to appear in the above publications, digital media and/or social media

_____ I do not give permission for my camper's photo to appear in the above publications, digital media and/or social media

Name of camper: _____

Signature of Parent/Guardian: _____ Date: _____

*Photo releases will remain in effect, unless The Arc of Essex County is notified in writing.

THE CANDLE LIGHTERS

Established in 1974, The Candle Lighters is a 501(c)3 organization dedicated to raising funds for The Arc of Essex County. Camp Hope is one of the organization's primary beneficiaries. To aid in these efforts, the organization may request the use of camp photos.

Photographs of campers may be taken and used for publicity purposes including but not limited to: publications in commercial periodicals; The Candle Lighters newsletters and social media; The Candle Lighters website; and various print, internet, and media publications of The Candle Lighters.

Please check one:

_____ I give permission for my camper's photo to appear in the above named publications, digital media and/or social media

_____ I do not give permission for my camper's photo to appear in the above named publications, digital media and/or social media

Name of camper: _____

Signature of Parent/Guardian: _____ Date: _____

*Photo releases will remain in effect, unless The Arc of Essex County is notified in writing.

(Over, please)

Camp Hope Liability Releases

(Required for Attendance)

Note: Initials needed on each section and signature at the bottom

A. Camp Hope and The Arc of Essex County reserve the right to release any camper from the Camp Hope program if, after a trial period, The Arc feels that it is not in his/her best interest to remain in the program.
_____ **Initials of parent or guardian.**

B. **RELEASE**: I,_____ , hereby release The Arc of Essex County, Camp Hope, and its employees of any responsibility or liability for any injury and/or illness derived from participation in the Camp Hope program. I acknowledge the conditions set forth above and agree with their contents in their entirety.
_____ **Initials of parent or guardian.**

C. I, _____, hereby give permission for my camper to participate in any off site field trips which are part of the day camping program.
_____ **Initials of parent or guardian.**

D. I,_____ , hereby give The Arc of Essex County, Inc. ("The Arc"), Camp Hope ("Camp") administration, and the medical personnel selected by the Camp Director (or his/her designee) permission to order X-rays, routine medical tests, and medical treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child, the below identified camper.

I understand that the Camp will make reasonable attempts to communicate with me prior to medical treatment in non-life threatening and other non-emergency situations, but that in accordance with the preceding paragraph, medical examination and treatment will be performed without necessarily communicating with me first or in life threatening and other emergency situations, even without attempting such communication. I give consent for transportation to a medical facility (by ambulance or school vehicle) in the event of an emergency.

I understand that the permission I have given by signing this form is a material inducement to acceptance of my child as a camper. I also confirm that I have given the Camp and The Arc of Essex County a complete and accurate medical history of my child.
_____ **Initials of parent or guardian.**

_____

Signature of Parent/Guardian Date

The Arc of Essex County
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CAMP HOPE
A Program of The Arc of Essex County

The Arc of Essex County
Camp Hope Health History and Examination Form for New and Returning Campers
(TO BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN)

A COMPLETE ANNUAL MEDICAL/PHYSICAL EXAMINATION AFTER JULY 2017 IS REQUIRED TO ATTEND CAMP

Name of Camper: _____

Camper's Address: _____ City: _____ State:_____ Zip: _____

Name of Physician: _____

Physician's Address: _____City: _____ State:_____ Zip: _____

Physician's Phone #: _____

ALLERGIES (List all known)

Medication Allergies	Describe reaction and management of the reaction
_____	_____
_____	_____

Food Allergies

_____	_____
_____	_____
_____	_____

Other Allergies – Include plant, animal, insect, asthma, etc.

_____	_____
_____	_____

RESTRICTIONS (List all that apply)

Dietary _____ Activities _____

_____ _____

_____ _____

(Over, please)

General Health Questions Camp Hope 2018

Does the camper have/had a history of:

	Current	History	Explanation of Current Status
A) Asthma			
B) Diabetes			
C) Frequent Colds			
D) Pneumonia			
E) Lung/Breathing Problems			
F) Seasonal Allergies/Other			
G) Ear Infections			
H) Frequent Headaches			
I) Serious Skin Problems			
J) Gum Problems			
K) Dental Problems			
L) Hypertension			
M) Heart/Circulatory Problems			
N) Stomach/Digestive Problems			
O) Kidney/Urinary Problems			
P) Pica (eats inedible objects)			
Q) Hepatitis B Carrier			
R) Seizure Disorder***			

*** Please complete the enclosed seizure form to provide the Camp Hope staff with details regarding the camper's seizure disorder.

To my knowledge this Health History Form is complete and accurate. The person herein described has permission to engage in all Camp activities except as noted.

Signature of Parent/Guardian Date

The Arc of Essex County
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CAMP HOPE
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CAMP HOPE PHYSICIAN'S EXAMINATION FORM – 2018

For New and Returning Campers

(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

A COMPLETE MEDICAL/PHYSICAL EXAMINATION AFTER JULY 2017 IS REQUIRED TO ATTEND CAMP

Name of Camper/Patient: _____

I have examined the individual named on this form.

Date of last OK examination: _____

Height_____	Ears_____	Heart_____	Skin_____
Weight_____	Nose_____	Lungs_____	Scalp_____
Pulse_____	Throat_____	Abdom._____	Spine_____
BP_____	Eyes_____	Hernia_____	Extm._____

In my opinion, this individual ◯ is ◯ is not able to participate in all camping activities. They may NOT participate in the following activities:

_____

_____

The individual is under the care of a physician for the following reason:

_____

_____

Diagnosis(s): _____

MEDICATIONS:

◯ This individual takes NO prescribed medications on a routine basis.

◯ The following medications are ordered for the person named on this form. (If a person is on ANY medications that will be administered during camp, even Ibuprofen, a prescription must accompany medications. The prescription must specify hour of day for administration (ex. 12:00 PM, not lunchtime). The prescription must also give specific instructions for administration (ex. grind pill, open capsule, take with food, etc.)

(Over, please)

CAMP HOPE PHYSICIAN'S EXAMINATION FORM -2017

(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

Medication*	Administration Times / Special Instructions
Med # 1 _____	_____
Med # 2 _____	_____
Med # 3 _____	_____
Med # 4 _____	_____

*If there are additional medications, please attach a separate piece of paper

Medically prescribed diet: _____

Treatment(s) administered at camp: _____

Known allergies: _____

IMMUNIZATION RECORD (FILL THIS SECTION OUT OR SEND A CHART COPY/PRINTOUT)

****UNLESS ACCOMPANIED BY A MEDICAL OR RELIGIOUS EXEMPTION, ALL CAMPERS MUST HAVE A COMPLETED IMMUNIZATION RECORD TO ATTEND CAMP.**

	Date	
MENINGITIS	_____	
DTP	_____	
TD (TETANUS/ DIPHTHERIA)	_____	
TETANUS	_____	
POLIO	_____	
MEASLES/ MUMPS/ RUBELLA	_____	
CHICKEN POX	_____	
TB MONTEUX*	_____	results _____
HEPATITIS	_____	
PNEUMOCOCCAL	_____	

*Within 1 year

Additional information for health care staff at camp:

_____

Signature of physician: _____ **Date:** _____

Name of physician (please print): _____

Address: _____

Phone #: _____

The Arc of Essex County
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CAMP HOPE
A Program of The Arc of Essex County

The Arc of Essex County's Camp Hope Program
Seizure Information Form – for New and Returning Campers
(TO BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN)

Name of Camper: _____

In an effort to provide the camper with the proper supports while they attend Camp Hope, please fill out the following information completely. This information helps the camp staff to understand what a TYPICAL seizure looks like for the camper.

IF YOUR CAMPER DOES NOT HAVE A SEIZURE DISORDER SIGN HERE:

_____ **does not have a seizure disorder as of this date.**
(name of camper)

_____
Signature of Parent/Guardian **Date**

If your camper has a seizure disorder, please complete and sign below.

History:

Events or behaviors just before a seizure begins: _____

_____

Time of day seizure typically occurs: _____

Length of time for Seizure: _____

Triggers: _____

Seizure classification: _____

When was the last seizure? _____

Description:

Lost consciousness _____

Falling _____

Noises _____

Irregular Breathing _____

(Over, please)

The Arc of Essex County's Camp Hope Program
Seizure Information Form

Movements:

Head and Face: Nodding _____ Jerking _____Twitching _____

Mouth: Sucking _____ Chewing _____ Lip Smacking _____ Grimacing _____

Eyes: Staring _____ Blinking _____ Rhythmic Movement _____

Other Symptoms:

Drooling _____ Tongue Biting _____ Dilated Pupils _____ Urination/ Soiling _____ Frothing _____

Sweating _____ Flushed _____ Vomiting _____ Pale _____ Goose pimples _____

Typical seizure lasts _____ minutes.

Does he/she usually have more than one seizure at a time? Yes ○ No ○

If yes, how many in a row? _____

Post Seizure Behavior:

Normal _____ Restless _____Sleepy _____ Confused _____ Deep sleep _____ Irritable _____

Other: _____

On the lines located below, please include any other information that may not have been included on the above checklist or to elaborate on any area:

_____

_____

_____

This seizure history is complete and correct as far as I know.

_____

Signature of Parent/Guardian Date

The Arc of Essex County
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CAMP HOPE
A Program of The Arc of Essex County

The Arc of Essex County's Camp Hope Program
Authorization to Apply Sunscreen
For New and Returning Campers

Camper Name: _____

Parent/Guardian Name: _____

I hereby authorize The Arc of Essex County's Camp Hope staff to administer the following sunscreen to the camper listed above:

TYPE OF SUNSCREEN	ADMINISTRATION TIME	PHYSICIAN'S INSTRUCTIONS (IF ANY)
1.	AFTER DAILY SWIM TIME	
2.	AFTER DAILY SWIM TIME	

This authorization covers the period in which the Camp Hope staff is providing care to the camper.

_____

Signature of Parent/Guardian Date

OR

Please **DO NOT** administer any sunscreen to the camper listed above.

_____

Signature of Parent/Guardian Date

The Arc of Essex County
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CAMP HOPE
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The Arc of Essex County
Authorization for Disclosure of Health Information (HIPAA)

Individual's Name:_____ Date of Birth: _____

I understand that the above named individual is using the services provided by The Arc of Essex County and The Arc of Essex County may require information from other agencies, providers, school districts or individual's in order to provide services. I also consent for The Arc of Essex County and the following designated agencies, school districts or individuals to disclose and communicate to one another information and records in their possession which relate to services and or treatment provided for the above named individual:

Name:	Division of Developmental Disabilities (DDD)	Name:	
Address:	153 Halsey Street, 2nd Floor	Address:	
	Newark, NJ 07107		
Phone:	973- 693-5080	Phone:	
Name:	Lenoirs Transportation and Charter Service	Name:	
Address:	15 First Street	Address:	
	Bloomingdale, NJ 07403		
Phone:	973-838-9180	Phone:	
Name:	New Jersey Children System of Care	Name:	
Address:	300 Horizon Drive, Suite 306	Address:	
	Robbinsville, NJ 08690		
Phone:	1-877-652-7624	Phone:	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	

My consent includes both verbal and written communication, which may include day-to-day observations of the following items (please initial beside each item you consent for):

_____ Medical and physical health records (excluding psychotherapy notes)
_____ Behavioral Health and Psychiatric records (excluding psychotherapy notes)
_____ Evaluation, assessment, and/or treatment information including occupational, physical, and/or speech therapies, audiological testing, etc.
_____ Evaluation materials including results of psychiatric evaluation, social work contact, psychological testing, medical, evaluation, learning disabilities consultation, and education classification report.
_____ Report of classroom and academic an/or vocational progress includes adjustments to teachers, peers, and general routines
_____ School records
_____ Other: _____

I understand I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the Chief Executive Officer at 123 Naylon Ave., Livingston, NJ 07039. The revocation will be effective the date the Chief Executive officer receives it.

I understand that I may refuse to sign this authorization. However, refusal to sign may limit The Arc of Essex County's ability to obtain information required to assess the support needs and/or services. I also understand that I may inspect and/or copy any written information used or disclosed under this authorization.

This authorization expires on_____ or one (1) year from the date of the individual's or legal guardian's signature.

_____

Signature (or mark) of Individual or Legal Guardian Date

_____

Print Name of Legal Guardian (if applicable)

If mark is provided in place of signature, the mark must be witnessed:

_____

Witness Signature Title

_____

Print Name of Witness

Check here if names are listed on an additional sheet ☐

The Arc of Essex County
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CAMP HOPE
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The Arc of Essex County's Camp Hope Summer ESY Program
School District Form 2018
For New and Returning Campers

_____, a student living in the _____school district, is
(Name of Camper) (Name of town)
requesting to participate in The Arc of Essex County's Camp Hope Summer Day Program to satisfy their ESY requirement.

Please complete this form and indicate which weeks the school district is approving the above student to attend The Arc of Essex County's Camp Hope Summer Day Program.

Upon receipt of this completed form, The Arc of Essex County will provide a contract to the district outlining services to be provided with fees. Contracts must be signed and returned prior to the start of camp.

Dates participant will attend Camp Hope through the district:

Week 1: July 2 – July 6	_____	Week 5: July 30 – Aug. 3	_____
Week 2: July 9 – July 13	_____	Week 6: Aug. 6 – Aug. 10	_____
Week 3: July 16 – July 20	_____	Week 7: Aug. 13 – Aug. 17	_____
Week 4: July 23 – July 27	_____		

Fees:

Camp tuition plus summer program:	$120.00 per day
One-to-one camp tuition plus summer program:	$220.00 per day
Transportation (Essex County Only):	$40.00 per day

_____ _____
Signature of School District Personnel Date

_____ _____
Printed Name Title

_____

_____

_____ _____
District Mailing Address Phone Number