
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: _____

Please provide the most effective ways your child communicates with others, including the use of any communication devices. If a communication device is used, will your child be bringing it to camp?

Please provide information about any physical conditions that would impact your child’s mobility and/or list any adaptive equipment your child will use during the camp day (i.e. braces, orthotics, etc.):

Please provide information for the following areas: what level of support is needed to successfully meet your child’s needs in regards to toileting, eating, and dressing?

Please describe any challenging behaviors your child may exhibit:

What are some helpful strategies/techniques that work in redirecting and/or reducing challenging behaviors?

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: _____

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

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 2019 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 2020

Does the camper have/had a history of:

	<u>Current</u>	<u>History</u>	<u>Explanation of Current Status</u>
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

CAMP HOPE PHYSICIAN'S EXAMINATION FORM – 2020

**For New and Returning Campers
(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)**

A COMPLETE MEDICAL/PHYSICAL EXAMINATION AFTER JULY 2019 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 – 2020
(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*	_____
HEPATITIS	_____
PNEUMOCOCCAL	_____

results _____

*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'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'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
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: <u>Division of Developmental Disabilities (DDD)</u>	Name: <u>New Jersey Children System of Care</u>
Address: <u>153 Halsey Street, 2nd Floor</u> <u>Newark, NJ 07107</u>	Address: <u>300 Horizon Drive, Suite 306</u> <u>Robbinsville, NJ 08690</u>
Phone: <u>973- 693-5080</u>	Phone: <u>1-877-652-7624</u>

Name: <u>Lenoirs Transportation & Charter Service</u>	Name: _____
Address: <u>15 First Street</u> <u>Bloomington, NJ 07403</u>	Address: _____
Phone: <u>973-838-9180</u>	Phone: _____

Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	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: _____

Authorization for Disclosure 4/03 *Individual is defined as the participant in The Arc of Essex County Services

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

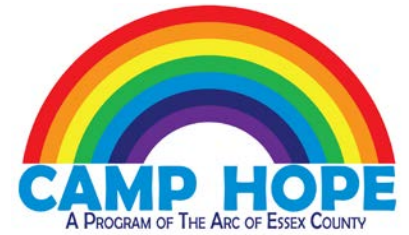
Print Name of Witness

Check here if names are listed on an additional sheet ()

Authorization for Disclosure 4/03 *Individual is defined as the participant in The Arc of Essex County Services



Achieve with us.



The Arc of Essex County's Camp Hope Summer ESY Program
School District Form 2020
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: June 29 – July 2 _____
Week 2: July 6 – July 10 _____
Week 3: July 13 – July 17 _____
Week 4: July 20 – July 24 _____
Week 5: July 27 – July 31 _____
Week 6: Aug. 3 – Aug. 7 _____
Week 7: Aug. 10 – Aug. 14 _____

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

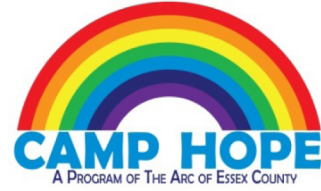
Printed Name

Title





District Mailing Address

Phone Number

Camp Hope Apparel Order Form



To order Camp Hope apparel, please complete the below form, including payment information, and return to Heather Comstock at hcomstock@arcessex.org or via mail at 123 Naylor Avenue, Livingston, NJ 07039. Items will be distributed on your child's first day of camp. Please email hcomstock@arcessex.org if you would like to arrange an earlier pick up date.

Item Information	Item Color	Size							
 <p>Camp Hope Cinch Sack & Water Bottle Duo</p>	Color: Charcoal & Blue	One Size							Item Total
	Cost	\$20.00							
	TOTAL								
 <p>Camp Hope Baseball Hat</p>	Color: Light Blue	One Size							Item Total
	Cost	\$20.00							
	TOTAL								
 <p>Youth & Adult Camp Hope Long Sleeve T-Shirt (Printed)</p>	Item Color	Yth Med	Adult Small	Adult Med	Adult Lrg	Adult XL	Adult 2XL	Adult 3XL	Item Total
	Color: White								
	Cost Each	\$16.00							
	TOTAL								
 <p>Youth & Adult Camp Hope Sweatshirt (Printed)</p>	Item Color	Yth Med	Adult Small	Adult Med	Adult Lrg	Adult XL	Adult 2XL	Adult 3XL	Item Total
	Color: Charcoal								
	Cost Each	\$25.00							
	TOTAL								
ORDER TOTAL (combine all item totals)									

Payment Details

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ Email: _____

Please bill my: AMEX Visa Mastercard I have enclosed a check made payable to **The Arc of Essex County**

Card Number: _____ CVV: _____ Expiration Date: _____

Signature: _____