



CAMP SOAR

Asperger's Related Services Camp SOAR Application

CAMPER APPLICATION AND REGISTRATION FORM (2009)

Completion of this form is necessary for admittance to the Camp Program.

In addition, prospective campers who are new to West Bergen will be interviewed by senior camp staff to determine if the child will benefit from the camp program.

1. Camper Information

Camper's Name: _____ Date of Birth: _____ Gender: () M () F

Grade: _____ School: _____ Sending District: _____

Home Address:

Street Apt# City Zip Code

Language(s) Spoken at home: _____ Does a parent speak English? Yes () No ()

Parent's Marital status: _____

Please list every member of the household:

NAME	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The camper is

Presently a client at West Bergen a former client at West Bergen Not and has never been a client at West Bergen

2. Family Information:

Parent-Guardian #1

Parent-Guardian #2

Name

Name

Relationship to the Camper

Relationship to the Camper

Address

Address

(_____) _____
Home Phone

(_____) _____
Home Phone

(_____) _____
Home Phone

(_____) _____
Home Phone

Work Phone
(____) _____
Cell Phone _____

Work Phone
(____) _____
Cell Phone _____

E-Mail (Please print clearly)

E-Mail (Please print clearly)

How did you find out about our camp? _____

3. Emergency Contacts:

Please identify **at least 2 and up to 4** people (**other than parent/guardian listed on previous page**) who may be called between 9 AM and 3 PM when you are not available.

Name:	Telephone:	Relationship to child:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

4. Trip Permission

I give my child permission to take walking trips and van trips with West Bergen Camp Staff.
() Yes () No

5. Dismissal Procedure

Parents are encouraged to pick up their child, if walking is not an option.

I give my child, who is 12 years of age or older, permission to walk home alone at dismissal time – 3:00 PM.
() Yes () No

People permitted to pick up my child:

Name	Relationship to Child	Day- Time Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you do not want your child picked up by a specific adult, please answer all of the following questions (A-C).

A. My child **MAY NOT** be picked up by the following individual because there is an active order of protection
Name _____ Docket # _____ Expiration Date _____

B. My child is aware of this order and will report this adult to a West Bergen Staff member
() Yes () No

C. I realize that there is no easy way of monitoring who picks up my child after camp. If I think this may be a problem, I will make an appointment with the Camp Director at 201-934-1160 to set up a special procedure for dismissal.

() Yes, I think there may be a problem () No, I do not anticipate any problems

6. About Your Child (please use separate page if necessary)

Child's strengths:

Child's Challenges:

Child's social communication ability (i.e. how often does your child appropriately and successfully initiate, maintain and end conversations with others, how does your child do communicating one on one vs in a group setting, etc.) :

Child's play activity and peer relationships (what does s/he like to play with, special interests, how s/he does with peers, types of relationships in his/her life, etc.):

Identify all sensory, motor, behavioral, nutritional or additional issues that would help us to work more effectively in making this a successful experience for your child:

Has your child had any incidents of aggression and/or self-injurious behavior at school, home or community during the last 12 months? Please describe.

Have there been any hospitalizations during the child's life for social-emotional-behavioral issues? This includes PESP visits, Emergency Room visits, emergency risk assessments or visits from Children's Mobile Crisis. If yes, please state when and describe briefly.

7. Release and Authorization

I give permission to Camp program staff and West Bergen Mental Healthcare or its agents to obtain education/psychological/medical/service information from my child's school, other educational sources, doctors, therapists, counselors, or other professionals if necessary in order to evaluate camp acceptance and placement. This authorization shall be effective until revoked by me in writing and delivered to the West Bergen Mental Healthcare Camp SOARs director.

Parent/Guardian Signature: _____ Date: _____

8. Photo/Video/Interview Consent

*I understand that the Camp Program features special events both in camp and away from camp where photos or videos may be taken. In addition, part of the social skills programming requires video taping campers practicing their skills and then reviewing those tapes. Please indicate your preference with regard to photos and videos by checking the choices below (Please initial all that apply):

- _____ I agree to allow my child to be photographed for the child to bring home
- _____ I agree to allow my child to be photographed for use within the groups at Camp
- _____ I agree to allow my child to be in a video for use within the groups at Camp
- _____ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen presentation aimed at increasing awareness and educating others
- _____ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen presentation aimed at increasing awareness and educating others
- _____ I agree to allow my child to be in a non-identifying photograph that may be used in a West Bergen publication
- _____ I agree to allow my child to be in a non-identifying video that may be used in a West Bergen fund-raising video

The undersigned, on his or her own behalf and on behalf of the child, as well as on behalf of all of the Undersigned and Child's heirs, successors and/or assigns, does hereby release WBMHC and its and their heirs, successors, and/or assigns from any and all claims, demand, and liability of whatever kind, including but not limited to payment of any compensation, for misappropriation or misuse of any publicity, trademark, copyright, or other rights of the Child and/or Undersigned and their heirs, successors and/or assigns, arising out of photographs/video of you or your child.

* _____

Parent/Guardian

Date

I give my child permission to participate in the Camp program.

All of the information I provided is true. I understand that all consent information I provided will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this summer camp program.

* _____

Parent/Guardian

Date

9. Payment Information

A minimum \$500 deposit is required at time of application for all campers. Applications must be completed in full and returned with all requested records. An interview may also be required. The application, record review and interview assist in predicting whether this camp is a good fit for your child. Any deposit/payment to be returned in full should applicant not be accepted or the minimal registration for camp program not be reached.

Full payment of balance due no later than June 15, 2009.

Total Enclosed: ___ \$500 Deposit ___ \$3,800 (six weeks) ___ \$2,000 (three weeks)
(check which payment is being made)

Check Am Ex MC Visa Other

Credit Card Number: _____ Ex. Date: _____

Signature: _____ by signature, I authorize the above credit card to be charged

10. Emergency Medical Care

Camper's Name: _____ Date of Birth: _____

1. If my child requires emergency medical care and I cannot be reached, I give my consent to the above camp program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child received. I understand that every effort will be made to contact me before and after medical care is provided.

2. Health/Insurance Information:

Camper's Primary Doctor: _____ (Fill in all information on this physician in first box below)

Insurance Company: _____ Policy Holder's Name: _____

Insurance ID Number: _____ Religious Preference: _____

11. Other Medical Information

Child's Primary Physician: _____ Type of Physician: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Child's Other Doctor: _____ Type of Physician: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
--	---

12. Services and Service Provider Information

Type of therapy/service your child is receiving: _____ Reason For Service: _____ Provider Name: _____ How long in this service: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Type of therapy/service your child is receiving: _____ Reason For Service: _____ Provider Name: _____ How long in this service: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
---	---

13. Other Provider Information (if applicable)

Case manager: _____	Therapist: _____
Address: _____	Address: _____
Reason For Service: _____	Reason For Service: _____
City: _____ ST: _____ Zip: _____	City: _____ ST: _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

14. Diagnostic and Classification Information:

Medical and/or Psychiatric Diagnosis: _____

Allergies: _____

Dietetic Needs: _____

Medication(s) and Dosages(s): _____

Copies of most recent diagnosis and evaluations, including IEP (if classified) MUST accompany this application

Diagnostic evaluation attached from _____

Evaluations attached – Identify _____

IEP attached (**Please include all evaluations and reports used to generate the IEP**)

15. Food Allergies

() I give permission for my child to eat meals or snacks provided by the program

() I do not give permission for my child to eat meals or snacks provided by the program. My child will bring his/her own snack and lunch.

() My child knows not to eat the foods mentioned below and will ask about the ingredients of a particular food if he/she is unsure of the contents.

FOOD ALLERGIES-RESTRICTIONS: _____

* _____
Parent/Guardian Signature

Date