Instructions for Fillable Camp Forms

1. Open 2019CampApplicationFillableForms.pdf file
2. Save completed form as "2019CampWarrenyourlastname" to your computer using action "Save As".
3. Fill out **all** information.
4. Print out **ALL** forms.
5. Sign where signature required.
6. Send all forms to:

The Arc Warren County Chapter
Attn: Recreation Department
PO Box 389
Washington, NJ 07782

OR- Email them to Marci as an attachment: mgubich@arcwarren.org

*If you have any questions you may call 908-689-7525 ext. 209

Camp Warren
Education & Recreation Center
2019 WEEK AND FEE SCHEDULE

Camper's Name ____

Receive a $50 discount (if paying with Cash/Check) off the total bill,
when camp weeks are paid in full by April 23rd

MARK THE BOX NEXT TO THE DATES YOUR CAMPER PLANS TO ATTEND.

☐ **DAY CAMP (Ages 5 & Over)**	
Monday through Friday 9:00 AM to 3:00 PM $575.00 per camp week *Includes accident insurance and transportation within Warren County*	
☐ Week of July 8	☐ Week of July 29
☐ Week of July 15	☐ Week of August 5 ***ages 21 and under**

☐ **ADULT RESIDENTAL CAMP (Ages 21 & Over)**
Includes all meals & snacks, and accident insurance *No transportation provided.*
☐ June 23rd – June 29th Sunday 1:30 PM to Saturday 10:00 AM $1,000.00 per camp week
☐ July 21st – July 27th Sunday 1:30 PM to Saturday 10:00 AM $1,000.00 per camp week

RETURN COMPLETED FORMS BY APRIL 23rd TO:

P.O. Box 389, Washington, N.J. 07882,
Attn: Recreation Dept.

CAMPER INFORMATION					
First Name			Last Name		Nickname
Date of Birth (MM/DD/YY)	Age		☐ Male ☐ Female		T-Shirt Size (Specify Youth/Adult Sizes)
Ethnic Background (Optional)		Height:			Weight:
Primary Contact Information *					
Name of Primary Caregiver					Relationship
Home Phone			Work Phone		Cell Phone
Secondary Contact Information *					
Name					Relationship
Home Phone			Work Phone		Cell Phone
***A responsible person must be available for contact during camp hours in case of emergency/illness, and for consultation.**					
Residing Information					
☐ With Family			☐ With Sponsor		☐ Independent
☐ Residential Placement (Group Home)					☐ Other
Street					
Apartment Number					
City			State		Zip Code
Mailing Address (if different from above)					
Post Office Box		Street Address/Apartment Number		Email Address	
City		State		Zip Code	
Transportation					
Transportation needed (available for day camp only)				☐ Yes	☐ No

Name of Person Completing Skills Assessment:

General Background (Please check all that apply)		
Disability (Check all that apply) ☐ Intellectual/Developmental/ Learning Delay ☐ Autism Spectrum Disorders ☐ Down's Syndrome ☐ Attention Deficit Disorder ☐ Emotional Disorder ☐ Behavioral Disorder ☐ Cerebral Palsy	☐ Spina Bifida ☐ Other (specify):	

Communication:	Vision: / Hearing:	Mobility: / Ambulation: / Transfer Assistance:
Communication: ☐ Verbal and can be clearly understood by others ☐ Verbal but may be difficult to understand ☐ Limited verbal vocabulary ☐ Uses communication board/device ☐ Uses sign language in addition to other mediums of communication ☐ Gestures ☐ No form of communication	**Vision:** ☐ Normal ☐ Mild/Moderate Loss in (L) (R) ☐ Severe/Total Loss in (L) (R) ☐ Wears Corrective Lenses Glasses –or- Contact Lenses **Hearing:** ☐ Normal ☐ Mild/ Moderate Loss in (L) (R) ☐ Severe/Total Loss in (L) (R) ☐ Wears Hearing Aids	**Mobility:** ☐ Independent/Unaffected ☐ Independent by ability affected ☐ Walks short distance with cane walker, or crutches **Ambulation:** ☐ Walks with direct staff support ☐ Uses wheelchair Manual -or- Powered **Transfer Assistance:** ☐ Independent ☐ 1 person ☐ 2 person ☐ 3+ person ☐ Mechanical Lift/ Hoist Only
Cognitive: ☐ No impairment ☐ Mild impairment ☐ Moderate Impairment ☐ Severe Impairment ☐ **Ability to Follow Instructions:** ☐ No Concerns ☐ Needs time to process/act ☐ Needs reminders/Cues ☐ Cannot process directions ☐ Does not follow directions	**Social/Emotional:** ☐ Initiates social contact with peers ☐ Has imaginary friends ☐ Willingly takes turns and shares ☐ Cooperates in group activities ☐ Willingly participates in new or unexpected activities ☐ Uses peers and resources ☐ Resolves conflict without using aggression or violence ☐ Responds differently to familiar or unfamiliar peers	**Behavioral Support Plan** ☐ **YES (PLEASE ATTACH)** ☐ **No** **History:** ☐ Head banging ☐ Wandering ☐ Physical aggression against others ☐ Biting ☐ Verbal aggression ☐ PICA (specify): ____________ ☐ Other: ____________________

Skill Help/Care Skills (Please check all that apply)

	Independent	Needs Verbal Prompts	Needs Gestural Prompts	Needs Physical Assistance	Unable to Perform
Toileting	☐	☐	☐	☐	☐
Personal Grooming	☐	☐	☐	☐	☐
Showing/Bathing	☐	☐	☐	☐	☐
Feminine Hygiene	☐	☐	☐	☐	☐
Dental Hygiene	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐

Restricted or Special Diet

Food Consistency	Liquid /Beverage Consistency
☐ Regular Diet ☐ Ground Diet ☐ Pureed Diet	☐ Thickened Liquid ☐ Not applicable Please describe thickness of liquids if applicable : ______________________________
Please list foods to avoid:	Please indicate any additional feeding instructions:

Camper Concerns

Does camper have specific fears? (please check all that apply)	For Residential Campers	Please describe bedtime routine:
Heights ☐ Yes ☐ No Darkness ☐ Yes ☐ No Water ☐ Yes ☐ No Storms ☐ Yes ☐ No Animals ☐ Yes ☐ No Strangers ☐ Yes ☐ No Other: ______________________________	Is this the first time sleeping away from home? ☐ Yes ☐ No Does camper experience bed wetting when sleeping away from home? ☐ Yes ☐ No	

Camper Interest

Does camper enjoy group activities?	Please indicate camper's favorite activities:
☐ Yes ☐ No	☐ Arts & Crafts ☐ Music ☐ Swimming ☐ Nature Walks ☐ Sports ☐ Quiet games ☐ Other

What areas of development do you feel we can aid in strengthening this summer?

HEALTH INFORMATION

History of seizures:	**Recent illness or injury:**	**Recent hospital stay:**
☐ Yes ☐ No Type: Last occurrence: Duration: Controlled by medication? ☐ Yes ☐ No	☐ Yes ☐ No Description:	**Reason:** Approximate length of stay: Approximate discharge date:
Chronic conditions ☐ Diabetic ☐ Insulin dependent ☐ Medication controlled ☐ Diet controlled ☐ High blood pressure ☐ Low blood pressure ☐ Asthma ☐ Chronic ☐ Exercise induced ☐ Seasonal/allergy related	**Allergies** ☐ No known allergies ☐ Food (please specify): ____________________ ☐ Medication (please specify):______________ ☐ Seasonal (please specify): ____________________ ☐ Environmental (please specify):________ ____________________	**Additional medical conditions** ☐ Excessive bleeding ☐ Menstrual complications ☐ Dizziness ☐ Skin conditions ☐ Other (please specify): __________________ __________________
☐ **Tetanus shot** **Date administered:**		Additional comments:
TB test **Date:** **Results:**		

I hereby certify that the above information is complete and accurate to the best of my knowledge.

Caregiver Signature: ________________________________ **Date:**________________________

MEDICATION FORM
Camper Name:
ALLERGIES:
Medications will need to be administered during camp hours. ☐**Yes** ☐ **No** When the administration of medication at camp is unavoidable, Camp Warren will accept a copy of the camper's prescription(s). If copies of prescriptions are not available, please have your physician complete and sign the form below.

List all current medications to be administered at Camp Warren, including PRN, vitamins and herbals. All medications must be in their original containers having labels with correct info.

See note below *

Medication	Dosage	Times of Administration	Purpose	Side Effects

Please use other side for additional space.

Care giver Signature: ____ **Date:** _____________

Physician Signature: ____ **Date:** _____________

*** Note: Upon arrival of the camper to the camp site, changes regarding the administration of medication(s) must be accompanied by copies of the new prescription(s) and forwarded to the Health Director or nurse. All prescription medications will be reviewed, signed and dated by both the care giver and the health professional at check-in. Medication must be provided in original marked containers in accordance with the physician's prescriptions. All medications will be discussed between the health professional and the care giver prior to return of the medications to**

the care giver.

Medication	Dosage	Times of Administration	Purpose	Side Effects

PERMISSION	
Camper Name	
Name of Legal Guardian	**Phone Number**
Address	

1. The undersigned agrees to give permission for the above named camper to participate in all Camp Warren activities, including field trips, in accordance with the program schedule, rules and regulations.

2. It is further understood that the Camp Warren program and The Arc, Warren County Chapter, Inc. are not liable for any accidents or medical expenses incurred while said camper is participating in the camp program.

3. It is also agreed by the undersigned that in the event that the above named camper becomes ill or has to be removed from the Camp Warren program for any reason, that the undersigned can be reached by telephone at the numbers previously listed on the camper application form, and that the undersigned or a person designated by the undersigned with written permission will call for said camper within an hour after receiving telephone call.

4. In an emergency situation, permission is hereby granted for the Camp Warren staff to call 911 for advanced medical care.

5. Permission to Publish: In permitting the above named camper to participate in the Camp Warren program, the undersigned is specifically granting permission to The Arc, Warren County Chapter, Inc. to use name, likeness, voice and words of the camper in television, radio, films, newspapers, magazines, and other media in any form, for the purpose of advertising or communicating the purposes and activities of The Arc, Warren County Chapter, Inc.

6. For campers **5 years of age** and younger, Camp Warren has my permission to release the above mentioned camper from transportation to any of the parties listed below. Written permission must be given for anyone not listed below.

Name___________________________________ Phone________________________
Address_________________________________ Relationship __________________

Name___________________________________ Phone________________________
Address_________________________________ Relationship__________________

7. In the event that camper funding through other sources is unavailable, the undersigned will notify The Arc, Warren County Chapter, Inc., and Recreation Services Department, immediately in order to apply for a campership, develop a private pay fee schedule or to cancel the camp reservation. If a reservation is cancelled under this circumstance, the undersigned will not be held responsible for the camp fee.

8. The undersigned understands that the Camp Warren Confirmation Letter is based on information which I have provided in this application and it is my responsibility to review the confirmation and **contact Recreation Services immediately**:

To correct information.
To cancel or change my requested weeks (At which time the Recreation Services Department will reschedule if space is available.)
To notify any changes in funding sources or if funding is unavailable.

9. The undersigned agrees that he/she will not be reimbursed for days which the above camper does not attend camp or camp or cancelled weeks after May 10th unless serious medical conditions or circumstances preclude attendance.

Parent/Guardian Signature: ____ Date: ____________________

Note: Must be signed by parent, legal guardian or camper if own guardian.

The Arc of Warren County
319 West Washington Avenue | PO Box 389
Washington, NJ 07882
Phone: (908)689-7525 | Fax: (908)689-2651

CONSENT FOR EMERGENCY MEDICAL TREATMENT

Consumer Name ______________________ **Date of Birth** ____________

Guardian ______________________ **Relationship** ____________

Address ______________________

Telephone - Home ____________ **Cell** ____________

PERMISSION TO TREAT

My signature below authorizes, in my absence, emergency medical treatment deemed necessary for the health and safety of ______________________.

Consumer Name

______________________ ______________________

Signature of Legal Guardian Date

****ALLERGIES**** ______________________

Primary Care Physician ______________________

Address ______________________

Phone Number ____________ **Fax Number** ____________

REFER TO MOST CURRENT MEDICATION LIST

Medicare	Medicaid	Other Insurance	Prescription Plan

Important Medical Conditions ______________________

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RELEASE OF INFORMATION

I hereby give permission to The Arc, Warren County Chapter, Inc. to release and/or obtain any necessary medical, psychological, educational or and/or work records concerning him/her for medical and professional services.

______________________ ____________

CONSUMER SIGNATURE **DATE**

______________________ ____________

PARENT, GUARDIAN OR GUARDIANSHIP WORKER SIGNATURE **DATE**

Revised 12-05-2017

FUNDING VERIFICATION

CAMP WARREN IS AN APPROVED PROVIDER FOR DDD, PERFORM CARE, AND MEDICAID FUNDING. Warren Arc is able to provide third party camperships to individuals or families who may require additional funding support and also meet the campership criteria. Please note that all payments have to either be approved or paid before the start of camper's stay. If you have any questions of concerns please call the main office. CHECK ALL THAT APPLY.

☐ SELF /PRIVATE PAY *FULL PAYMENT IS DUE PRIOR TO THE START OF CAMPER ATTENDANCE. RECEIVE A $50 DISCOUNT IF PAYING IN FULL BY APRIL 23, 2019.	PARTY TO BE BILLED: * I HEREBY CERTIFY THAT I AM RESPONSIBLE FOR THE PAYMENT OF CAMP FEES IN THE AMOUNT OF $______________ SIGNATURE:____
☐ DDD FAMILY SUPPORT SERVICES *FAMILY SUPPORT ADVISES THAT ALL PARTICIPANTS APPLYING FOR RESPITES BE ABLE TO PAY FULL FEE AS FUNDING IS BASED ON A YEARLY FISCAL AVAILABILITY.	DDD CASE # ______________________________________ SUPPORT COORDINATOR: ____________________________ EMAIL: ____ PHONE: ( ) -
☐ PERFORM CARE *CAMP FORMS NEED TO BE IN BY DEADLINE IN ORDER TO SEND PERFORM CARE CONFIRMATION.	PERFORM CARE ID # ________________________________
☐ CAMPERSHIP *APPLICATION FORMS MUST BE SUBMITTED BY APRIL 23, 2019.	REQUEST FOR CAMPERSHIPS MUST BE MADE BY COMPLETING THE ENCLOSED CAMPERSHIP APPLICATION FORM. THE RECREATION DEPARTMENT WILL NOTIFY YOU IF YOUR APPLICATION IS APPROVED.
☐ OTHER/THIRD PARTY SPONSORSHIP *LETTER OF INTENT TO PAY MUST BE RECEIVED FROM THIRD PARTY SPONSORS.	CONTACT NAME: _________________________________ ADDRESS: ______________________________________ ____ PHONE: ( ) -
☐ ONE TO ONE *CAMP WARREN WILL HIRE & TRAIN A ONE TO ONE AIDE AT AN ADDITIONAL COST.	I PLAN TO PAY FOR THE ADDITIONAL ONE TO ONE COST BY: ☐ SELF-PAY : $13.50/HR FOR 30 DAY CAMP HOURS $13/50/HR FOR 140.5 OVERNIGHT HOURS ☐ DDD FAMILY SUPPORT SERVICES ☐ PERFORM CARE

FINANCIAL AID	CAMPERSHIP APPLICATION

The Arc, Warren County Chapter, Inc. raises funds, through our annual RADIOTHON for families in the Warren County area that require financial assistance to send a camper to Camp Warren. The administration of these funds is not guaranteed and is determined based on need and availability. Campership applications are required to be completed and **returned by April 23, 2019**. The applicants will be informed of the status of their camperships as soon as possible.

Camper Name:
Annual income (please include household income if camper is under age of 21):
Please indicate extraordinary financial hardships camper and/or household has experienced in past year:
Please indicate reasons for applying:
Number of weeks for which funding is requested:
Total financial assistance requested for one to one aide (if applicable): $
Total financial aid requested: $

You may be required to provide information which corroborates your request.

I hereby certify that the above information is accurate to the best of my knowledge.

Caregiver Signature: ____ **Date:** ___________

If interested in participating in RADIOTHON in April 2019, please contact the Warren Arc Office and/or check out our website www.arcwarren.org for updated information and phone number to make pledges the day of.

Donations through RADIOTHON are tax deductible and can be designated for a specific camper