



**KIDS KAMP 2011
Intake Packet**

CAMPER INFORMATION FORM

DATE _____

Camper Name _____ D.O.B _____ Age _____ Race _____ Gender _____

Address _____ City _____ State _____ Zip _____

Phone _____ County _____ Has camper attended
Kids Kamp before? _____

Caregiver Information:

Parent/Grdn. 1 _____ Parent/Grdn. 2 _____
(H) _____ (C) _____ (H) _____ (C) _____

Who does the youth currently live with?

Who has custody of the youth?

List everyone that is authorized to pick your child up from Camp:

Emergency Contact:

Name: _____ Phone: _____ Relationship to youth: _____

Child's Diagnosis: Please check all that apply.

___ADD ___ADHD ___ED/BD ___MRDD ___OCD ___ODD
___PDD-NOS ___RAD ___Anxiety ___Aspergers ___Autism ___Bi-Polar
___Other: please explain _____

A B K F MRDD FAMILY DYNAMICS EMOTIONAL/BEH

OFFICE USE ONLY

Funding Source: _____	Approved or Pending		
Case Manager: _____	Phone# _____		
ISP Rec'd Date _____	2020 Rec'd Date _____	Profile Rec'd Date _____	
Weeks attending _____	Transport Y / N	Photo Y / N	Ratio _____

CHILD BACKGROUND INFORMATION:

Describe your child’s special needs and disabilities and why they need to attend Kids Kamp:

List your child’s strengths and special positive characteristics:

List current behavioral problems that may include physical or verbal aggressive behaviors:

Does the child have any sexual behavioral problems or been identified as a sex offender?

How best does your child communicate his/her wants and needs?

Does your child currently participate in mental health counseling? If yes, where and who?

Is the youth currently on probation or under the supervision of the Juvenile Courts? If yes, why?

CHILD’S INTERESTS AND DESIRES

Has the child ever attended a camp before? If yes, when and where?

What activities does your child enjoy?

What activities does your child **not** enjoy?

What other information should the camp staff know about your child?

Does your child wear glasses or hearing aids?

Does your child have any physical restriction? Please explain.

Does your child have any dietary restrictions? (allergies, vegetarian, etc.) Please explain.

List any medical concerns, allergies, or conditions not listed above that staff should be aware of.

AUTHORIZATION TO ADMINISTER SPECIFIED MEDICATION

I hereby authorize Respite Connections staff and/or respite providers to administer the listed medications prescribed by his/her physician to _____.

Camper's medication MUST accompany him/her to camp in the correct prescription bottles. If camper arrives at camp without their medication, camper will not be permitted to stay at camp. If the medication does not come in the correct bottles then the camper will not be allowed to remain in camp.

All attempts will be made to administer the above medications to the child, but we can not guarantee that they will be taken. If this has been a concern in the past, please explain:

Parent's signature

Date

Current Medications Date:

Dr.

Medication	Dosage	Time(s)	Prescribed for

CONSENT FORM

CLIENT'S NAME: _____

Kids Kamp staff is committed to providing the highest level of therapeutic and safe environment for your child. Signing this form indicates that you understand the services provided by our program and that you would like your child to participate in Kids Kamp. Initialing beside each of the specialized activities listed below indicates that you are permitting your child to participate in such activities while attending Kids Kamp.

ACTIVITIES CONSENT

Children who participate in the Summer Kids Kamp program will be participating in a number of indoor and outdoor activities. Staff will provide constant supervision of all youth in the program to minimize the potential for physical injuries. Initiating in this area indicates that you are permitting your child to participate in general art, recreational, music and educational activities with the understanding that all camp activities will have a therapeutic focus and benefit to the participants involved. _____

Initialing beside each of these identified activities gives your child permission to participate in these specific activities that may be more physically involved and have a greater risk of injury than other more general activities.

_____ Horseback Riding _____ Canoeing _____ Roller Skating _____ Swimming

MEDICAL CONSENT

I knowingly and voluntarily authorize Respite Connections to procure such emergency medical, dental, or optical treatment upon competent medical advice, as deemed necessary and in the best interest of my child. I understand that except in the case of a life-threatening emergency, I will be notified in advance of any serious medical, dental or optical problems requiring treatment. Respite Connections shall not be liable for the performance of such medical care, which will be procured only upon the advice of a licensed physician. _____

PHOTO/VIDEO MATERIALS CONSENT

I understand that Respite Connections collects photographs of children during therapeutic activities and special events. I give my permission for my child to be photographed and videotaped as it relates to their respite care services. I understand that no pertinent identifying data will be given to the media or used for any publicized activity without first getting my written permission. _____

TRANSPORTATION CONSENT

I give permission for Respite Connections staff, respite care providers and volunteers to transport my child in their own personal and/or agency care/van/truck as needed. I understand that they will have the State minimum of liability insurance. I also permit my child to travel outside of our county in order to participate in Kids Kamp activities. I understand that I will be notified before my child leaves the county for such activities. _____

Signature of Parent/Guardian

Relationship to Client

Date

Witness

Title

Date

Statement of Restitution

I agree to take financial responsibility for any and all damage, including destruction of property, theft of camp, client, or staff belongings, that my child, _____ does while attending the Kids Kamp program. I understand that if I do not pay for these damages, Respite Connections may take legal action against me.

Signature of Parent/Guardian

Relationship to Client

Date

RELEASE OF INFORMATION

Respite Connections is hereby granted permission to communicate with and exchange information with:

(Name, title and address of person or agency that RCI will exchange information with.)

Such information as may be necessary regarding the case of:

(Print or type full name of client)

(D.O.B.)

(Social Security #)

Purpose or need for disclosure of information: Continuity of Care: YES NO
Other (specify):

Extent or nature of information to be released:

___ Psychosocial history

___ On-going treatment of child

___ Summary of services

___ Contracts

___ Other (specify):

___ Financial Arrangements

Records and information that are not to be released are:

This authorization may be revoked by me in writing at any time.

Parent/Guardian/Legal Custodian parent

Date signed

Relationship to client

(Signature of witness)

(Date signed)

I wish to revoke my consent to release information.

(Client or authorized person)

(Date signed)

(Witness)

(Date signed)

NOTE:

This information is being disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.



TEACHER QUESTIONNAIRE

Respite Connections is hereby authorized to communicate with and exchange information with:

_____ (name, title, and address of person that RCI will exchange information with)

regarding the following student: _____. I understand that information disclosed will be kept confidential and will only be used to provide quality care and programming for the individual named above. I understand that this authorization may be revoked by me at any time in writing.

_____ (parent/guardian/legal custodian)

_____ (date)

Dear Teacher/Counselor,

Thank you for taking a moment to fill out this questionnaire. Respite Connections provides a summer day camp experience for children with disabilities. Our mission is to provide a continuum of therapeutic and wellness support services to individuals of all ages in order to assist them in achieving their individual goals and reaching their fullest potential. This questionnaire is an important part of providing a successful summer of socialization, fun, and friendship. Your candid responses are appreciated.

1.) In what capacity do you know the above student?

___ Teacher ___ Counselor ___ Intervention Specialist ___ Social Service Provider

2.) Student's Diagnosis and/or tendencies? Please check all that apply:

___ ADD ___ ADHD ___ ED/BD ___ CD ___ DD ___ LD ___ OCD ___ ODD ___ MR ___ PDD-NOS

___ PTSD ___ RAD ___ SLD ___ Anxiety ___ Aspergers ___ Autism ___ Bi-polar

___ If Other, Please Explain: _____

3.) Student's school placement? Please check all that apply:

___ public school regular classroom ___ public school regular classroom with tutoring/inclusion

___ public school self-contain classroom ___ day treatment program ___ homeschooled

___ private/charter school: please explain: _____

___ other: please explain: _____

4.) Three ways your student is successful:

1. _____

2. _____

3. _____

5.) What specific needs does the student have in regards to toileting, hygiene, meals, etc.: _____

6.) To your knowledge does this student have issues with authority_____ If yes, please explain: _____

7.) Does this student have behavioral issues? _____ If yes, please explain: _____

8.) If you answered yes to the above question, please explain what strategies are used to successfully deal with those behaviors.

9.) What staffing ratio do you feel that this student will need to be successful? 1:1, 1:2, 1:3, 1:6
Please explain: _____

10.) Please use the space below to share any other information you feel would be beneficial to the staff in providing your student with the most successful camp experience.

Name (Please Print) Title/Position

___ Please send additional information about Respite Connections to give to other students.

Name _____
Address _____

I would like _____ copies of the summer camp brochure.

**Please mail this completed form to: Respite Connections
5250 Strawberry Farms Blvd.
Columbus, OH 43230**

**If you would like to know more information about Respite Connections, please:
Visit our website: www.respiteconnections.org
Call our office: 614-890-HELP (4357)**

IMPORTANT INFORMATION AND REMINDERS

This page is intended to be used as a continuous reference. Please keep it for your records.

Important Dates for Summer 2011

Camp Open House: June 5, 1:00pm

Session 1: June 13-17

Session 2: June 20-24

Session 3: June 27-July 1

Session 4: July 5-8 (No camp on July 4)

Session 5: July 11-15

Session 6: July 18-22

Session 7: July 25-29

Session 8: August 1-5

Session 9: August 8-12

Session 10: August 15-19

Family Day: August 19, 1:00pm

Camp Open House, scheduled for June 5th, is for new and returning campers and their families. The purpose of the Open House is to familiarize campers with the Respite Connections staff, program, and facilities. Campers and siblings get the opportunity to meet staff and other campers, and parents have the chance to ask any questions they have following a short presentation by the Camp and Agency Directors. Attendance is highly recommended, and a cookout lunch is provided.

Each day, transportation pick-ups are at 8:00am and drop-offs are at 4:00pm. Please plan to arrive at your designated drop-off location at least 5 minutes before your scheduled time. You will receive exact drop-off address one week before camp begins. If you need staffing before or after camp, or 1:1 transportation, please call our office and speak to Karie to arrange.

WHAT TO BRING TO CAMP:

Packed lunch each day

Swim suit and towel (refer to weekly schedule)

Water Bottle

Medication (in original bottles)

DO NOT BRING:

Electronics Weapons

Valuables Money

TRANSPORTATION POINTS

- I-270W & I-70W (W)
- I-270W & Broadway (SW)
- I-70E & S. Hamilton Rd (SE)
- I-670 & Leonard Ave (Central)
- I-270 W & OH-161 W (NW)
- US 23 & US 42 (Delaware)
 - I-71 & OH-161 (N)
- 5250 Strawberry Farms Blvd, Columbus, OH (will be open at 7:30am for those needing early drop-off, and until 5:00pm for late pick-up)

Please use the following address for directions to Open House and Summer Camp:

**Franklin Church
7171 Central College Ave
New Albany, OH 43054**

Contact Information:

**Camp Director: Mariane Roberts
Cell: 614-735-7444
Office: 614-890-4357 ext 111
Executive Director: Mary Wright
Cell: 614-774-1120**