

The Children's Center For Neurodevelopmental Studies
SUPER SUMMER ADVENTURES
SUMMER DAY CAMP

Session 1 (6/13/11 - 7/1/11) [] **Session 2** (7/5/11 - 7/22/11) []
Session 3 (7/25/11 - 8/5/11) []

APPLICATION

Date: _____

Student Information:

Student's Name: _____ Date of Birth: _____

Diagnosis/Physician: _____

Parent(s)/Guardians Name: _____

Address: _____ City: _____ zip: _____

Home Phone: _____ Work/Cell Phone: _____ Email address: _____

Does your child have any of the conditions below:

- seizure disorder: _____ metabolic disorder: _____
 cardiac disorder _____ respiratory/asthma: _____ diabetes _____
 bone/muscle/joint condition: _____ prosthesis/orthotics: _____
 past surgeries: _____ past hospitalizations: _____
 allergies: _____ other _____
 medications: _____

Is your child:

Ambulatory: ___yes ___no Independent in feeding: ___yes ___no Independent in bathrooming: ___yes ___no
Verbal: ___yes ___no Special Communication needs: _____

Does your child have any special dietary concerns? ___yes ___no

Please list: _____

Interests, hobbies, past activities:

List your child's strengths: _____

List your child's needs: _____

What is your goal(s) for your child's participation in this program? _____

List your child's sensitivities and/or sensory needs: _____

Indicate any strategies to aid your child's success:

- visual schedule chewies/oral toys fidgets, transitional objects other _____

Can your child participate safely with a 1:6 ratio? ____yes ____no

Does your child have any behaviors that may interfere with successful participation:_____

escape/running away behavior: __Y __N self injurious behavior __Y __N
aggressive behavior __Y__N

Situations/environments/events that may upset your child:_____

How does your child express their frustration:_____

Does your child get along with other children: Yes No

Does your child get upset if he/she does not win a game: Yes No

Does your child wander off or run away from you in outdoor/community environments: Yes No

Does your child put dirt, rocks or other items in his mouth while outside: Yes No

Can your child: Throw/catch a ball Yes No

Kick a ball Yes No

Swim Yes No

Ride a bike Yes No

Transition between activities Yes No

Stay with one activity until completion Yes No

Tolerate small groups Yes No

Play safely on playground equipment Yes No

Walk short distances (5-10 blocks) Yes No

Any limitations for physical activity participation: Yes No

Any other information you would like us to know about your child:

*****Please note: In order to best meet the needs of all participants; all applications are subject to review and acceptance. Once application is received a recreation therapist will contact you to schedule an interview(either over the phone or in person) .**

***Space is very limited; please return your child's application ASAP to address below.**

Parent/Guardian Signature:_____

Please mail application to:

Super Summer Adventures C/o: C.C.N.S. 5430 W. Glenn Dr., Glendale AZ 85301

Are you interested in using Habilitation and/or Respite hours in the afternoon? **YES / NO** (circle one)

Emergency contact information and permission for participation

Emergency Contact information:

Participant's name: _____ age: _____

Parent/guardian: _____

Address: _____

day phone: _____ cell phone: _____ evening phone: _____

In case of an emergency contact: Name _____

****required**

phone: _____ alternate phone: _____

****required**

Parent/guardian permission to participate:

I _____ (parent/guardian) give permission for
_____ (participant) to participate in The Children's Center ***Super Summer
Adventures*** program. I acknowledge that this is a therapeutic recreation program that will include outdoor activities such as swimming, water play, community outings, bus transportation, play ground activities, games/sports, gymnastics, mounted horseback riding, etc. I realize that while close supervision will be provided and all precautions will be taken, the possibility of an accident or medical emergency cannot be ruled out. I assume responsibility for any medical treatment which may become necessary.

parent/guardian signature

parent/guardian - printed name

date

Participants Medical History and Physicians Statement

Participant Name: _____ DOB: _____

Address: _____

Parent/guardian _____

Diagnosis: _____

Tetanus shot: [] yes [] no Date: _____ height: _____ weight: _____

Seizure type: _____ Controlled [] yes [] no precautions: _____

Medications: _____

**** for person's with Down's Syndrome**

[] negative cervical X-ray for Atlantoaxial Instability X-ray date: _____

[] Negative for clinical symptoms of Atlantoaxial instability

Please indicate if patient has a problem and/or surgeries if any of the following areas by checking yes or no. If yes please comment.

Areas	yes	no	Comments
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Visual			
Auditory			
Speech			
Learning Disability			
Mental Impairment			
Psychological			
Metabolic disorder			
other			

Mobility: Independent ambulation [] yes [] no **orthotics/prosthesis:** _____

Ear Health: tympanotomy tubes [] yes [] no **chronic ear infections** [] yes [] no

To my knowledge there is no reason why this person cannot participate in a supervised therapeutic recreation program that may include swimming, sports, physical games, equestrian activities, play ground activities, bicycle riding, horticulture, gymnastics, and other active recreational therapy activities.

Physician name (please print) _____

Physician Signature _____

Date _____ *phone* _____