# CAMP TREASURE CHEST APPLICATION
2019

This form is to be completed and retained at the service delivery site.
**For ages 6-21 only who are DDSN eligible!**
**$60.00 application fee**

## I. PERSONAL INFORMATION

Applicant's Name _____

Address_____

Zip Code_____ Telephone#:_____

Date of Birth_____ Sex____ Race_____ Medicaid #:_____

Parent/ Guardian's Name_____

**T-Shirt Size**: Youth or Adult XS S M L XL XXL XXXL

Emergency Contact _____
(If different from above) Name Telephone Number

I hereby authorize emergency medical care to be provided to my son/daughter in the event an emergency situation warrants such treatment.

_____
Signature/Relationship Date

Please describe special needs and/or physical limitations that your son/daughter has which should be brought to the attention of the Summer Services Program staff that would prevent his/her full participation in program activities:

_____

_____

_____

II. **FAMILY SUPPORT NETWORK** Please list all family members residing in household:

| Name | Relationship | Age | Employed (Circle one) |
|---|---|---|---|
| | | | **Yes No** |
| | | | **Yes No** |
| | | | **Yes No** |
| | | | **Yes No** |
| | | | **Yes No** |
| | | | **Yes No** |

III. **ENTRANCE CRITERIA** - To be completed by a **caregiver and case manager**.

A. Intellectual range (AAMR)*
1. Mild (IQ 52-70)
2. Moderate (IQ 36-51)
3. Severe (IQ 21-35)
4. Profound (IQ 0-20)
5. Undetermined (attach enrollment justification if undetermined)

Date of Psychological _____

B. Accompanying Disability:

1. Autism
2. Motor handicap
3. Cerebral Palsy
4. Seizure disorder
5. Orthopedic handicap
6. Emotional handicap
7. Communication disorder
8. Partial loss of vision
9. Total loss of vision
10. Partial loss of hearing
11. Total loss of hearing
12. Major health problems
13. None

Describe special needs and/or limitations that would prevent this client's full participation in program activities:

_____

_____

C. Does your son/daughter require a shadow during the school year? _____yes _____no

If yes,
why?_____

## IV. MEDICAL EVALUATION

**This form is to be completed with appropriate signatures and is to be retained in the Camper's File at the service delivery site.**

Camper information: Name _____

Program _____***Camp Treasure Chest***_____

Check Atypical only.

____ Head & Face
____ Eyes, Vision
____ Nose
____ Mouth & Throat
____ Neck
____ Ears, Hearing
____ Thorax, Lungs & Breast
____ Heart
____ Vascular
____ Abdomen
____ Spine & Neck
____ Body Marks
____ Skin
____ Lymphatic
____ Neurologic
____ Psychiatric
____ Hernia
____ Anus/Rectum
____ G.U. System
____ Endocrine System
____ Extremities

COMMENTS: (Indicate special medical needs, physical limitations, and medications received)

_____
_____
_____
_____

Based upon my examination, this person appears to be able to participate in: (check one)

____ Physical Activities _____Not participate in Physical Activities

_____
Physician's Signature Date Telephone Number

_____
Street City State Zip Code

SEIZURES HISTORY ____ Yes ____ No (If yes, read and sign below)
I hereby permit my son/daughter to participate in waterfront, aquatic, and swimming activities with the knowledge that appropriate safety procedures have been established for campers who experience seizures.

_____
Signature/Relationship Date