Camp Lenape
Sponsored by
United Cerebral Palsy of Delaware, Inc.
3249 Midstate Road
Felton, De 19943
Office (302) 335-5626
Fax: (302) 335-5716

January 26, 2017

Dear Parents:

United Cerebral Palsy of Delaware, Inc. will conduct a summer day camp for children and young adults with and without disabilities who reside in Kent and Sussex counties. Children with disabilities range from ages 3 to 21 and without disabilities from 6 to 12.

Camp will operate weekdays from 7am to 6pm, beginning July 3, 2017 and run for 6 weeks until August 11, 2017. There is no camp on Tuesday, July 4th!! DART Paratransit is available for those who are eligible and need it! UCP does not provide transportation. Please start arranging your child's transportation as early as possible. You can call DART for an application.

While campers are encouraged to attend the full 6 week session, it is possible to attend one week only. Enclosed is an application, together with the **Medical and Registration forms.** Complete the entire application, and return to us before June 25, 2017! **The physical form must be completed and filled out by your child's doctor when he/she receives their physical.** Your child's medical form must be returned to us before the date that camp starts. **There are no exceptions to this!!!** Your child/children cannot come to camp until we have the Physical form that has been completed by the camper's doctor. Please schedule your child's physical as soon as possible as many times it takes a month or so before your doctor can see your child. The physical can be faxed to Carma L. Carpenter at (302) 335-5716.

There are 2 **fees for Camp Lenape this year. If your child is only attending the regular camp program session from 9am to 3pm the fee is $130.00 per week. If your child/children are attending any other hours from 7am to 6pm, the charge is $145.00 per week. If your child is attending the 9 to 3pm camp session only, your child must be dropped off at 9am only and picked up by 3pm only. There is a $25.00 non-refundable registration fee that is due when you mail back your application.** Campers who qualify for **State of Delaware Purchase of Care** can contact 211 to find out how to apply. **Campers who receive Purchase of Care do not pay the $25 registration fee. If your child is a client of the Division of Developmental Disabilities Services** you can contact them to see if your child can receive funding for camp.

Our programs are **Arts and Crafts, Music, Nature, Swimming and Sports. We also go on field trips to the Delaware State Fair, Bowling, Fishing and a trip to the Frederica Fire Company and the Biggs Museum! We have different events at camps such as Ronald McDonald, Exotic Birds, local bands and much more.** Please register as soon as possible.

If you have any questions or need help with the forms, please call Carma Carpenter at (302) 335-5626. We are looking forward to seeing your child/children at Camp Lenape 2017.

Sincerely,

Carma L. Carpenter
UCP Director/Social Worker
3249 Midstate Road, Felton, De 19943
Kent and Sussex Counties
ccarpenter@ucpde.org

UNITED CEREBRAL PALSY OF DELAWARE, INC.
CAMP LENAPE ~ CAMPER APPLICATION

3249 Midstate Road Felton, DE 19943
Office 302-335-5626 Fax 302-335-5716

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Camper Information

Full Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Age: _____ Gender (circle one) Female Male

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Please select how you plan to pay for camp ☐ Self-pay ☐ Purchase of Care ☐ Other

Camper's Health Information

Do you or your camper have a disability? ☐ Yes ☐ No If so, check all that apply

☐ Asperger's Syndrome
☐ Asthma
☐ Attention Deficit Disorder/AHDH
☐ Autism
☐ Behavior Disorder
☐ Bleeding/Clotting Disorder
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Diabetes
☐ Developmental Disorder
☐ Down Syndrome
☐ Epilepsy/Seizure Disorder
☐ Fragile X
☐ Hearing Impaired
  ☐ Partial ☐ Total
☐ Heart, Circulatory, Respiratory Defect
☐ Intellectual Disabilities
  ☐Mild ☐ Moderate ☐Severe/Profound
☐ Learning Disability
☐ Muscular Dystrophy
☐ Psychosis
☐ Speech-Language/Voice Dysfunction
  ☐ Non Verbal
☐ Spina Bifida
☐ Spinal Cord Injury
  ☐ Quadriplegic ☐ Paraplegic ☐ Other
☐ Social/Psychological
☐ Visual Impairment
  ☐ Partial ☐ Total
☐ Other Disability (s) _____
_____
_____

UCP United Cerebral Palsy of Delaware, Inc.
Life without limits for people with disabilities

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PLEASE TYPE OR PRINT CLEARLY

Camper Name _____

Parent/Caregiver Information

Custodial Parent/Guardian: _____ Relation to Camper: _____
E-Mail Address: _____ Home#: _____

Employer: _____ Work#: _____ Cell#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Custodial Parent/Guardian: _____ Relation to Camper: _____
E-Mail Address: _____ Home#: _____

Employer: _____ Work#: _____ Cell#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Additional Contact Information

Emergency Contact #1: _____

Relation to Camper: _____ Phone #: _____

Emergency Contact #2: _____

Relation to Camper: _____ Phone #: _____

Referral Information

Has camper ever attended UCP of DE's Camp Lenape before? ☐ Yes ☐ No

If yes, please list the year (s) camper attended _____

If no, please tell us how the camper found UCP of DE's Camp Lenape:

☐ Family Member _____ ☐ Other Camper _____
☐ Camp Fair _____ ☐ School _____
☐ Website _____ ☐ Social Service Agency _____
☐ Other _____

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Additional Camper Information

Mobility ☐ Walks ☐Walker ☐ Wheelchair ☐ Can propel/drive self

Transfers ☐ No assistance needed ☐ Needs Assistance (explain) _____

Assistive Devices ☐None ☐ AFO's ☐Glasses ☐Hearing Aid

☐Helmet ☐Other _____

Communication ☐ No serious difficulties expressing thoughts or wants

☐ Has difficulties (explain) _____

☐ Uses sign language ☐ Uses a communication device (what kind?) _____

Eating ☐No assistance Needed ☐Needs assistance (explain) _____

Diet ☐Normal ☐Blended/Pureed ☐Diabetic ☐Gluten Free ☐Feeding Tube

☐Food Allergies (list) _____

Bowel Control ☐No assistance Needed ☐Incontinent

☐ Needs Assistance (explain) _____

Bladder Control ☐No assistance Needed ☐Incontinent

☐ Needs Assistance (explain) _____

☐Catheter ☐Urinal ☐Disposable Undergarments ☐Other

Dressing ☐Assistance Needed ☐No Assistance Needed

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PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Camper's Social Background

School/Employer: _____

Grade: _____ School Phone Number: _____

Does your Child have a State Case Worker? ☐ Yes ☐No

Case Worker: _____ Phone #: _____

Can the camper read? ☐Yes ☐No Write? ☐Yes ☐No

Does the camper have any special behavior or sensory challenges? ☐Yes ☐No

If yes, please describe:

_____

_____

When do behavior problems occur?

_____

_____

Describe effective methods to redirect or prevent behaviors:

_____

_____

Does the camper have a Behavior Intervention Plan (BIP) or an Individualized Education Program (IEP) at school? ☐ Yes ☐ No (If yes, please submit a copy to UCP)

Does the camper have temper tantrums that will intensify into aggressive and destructive behavior? ☐ Yes ☐ No If yes, how do you help him/her de-escalate?

_____

_____

Please list any fears the camper may have: _____

Please list any activities the camper dislikes: _____

Is your camper able to participate in the camp swimming program: ☐Yes ☐ No

If yes, any pool restrictions? _____

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PLEASE TYPE OR PRINT CLEARLY

Camper Name _____

Camper's Health Information

Please list any medications the camper uses

1. _____ 2. _____

3. _____ 4. _____

Seizures ☐ Yes ☐ No Type _____ Frequency _____
Describe any warning signs before seizures: _____

Allergies ☐ None ☐ Hay Fever ☐ Poison Ivy ☐ Insect Stings ☐Penicillin
☐ Other _____

Psychiatric Treatment/Counseling Has the camper ever required any psychiatric treatment/counseling or hospitalizations? ☐ Yes ☐ No
Please Summarize _____
_____

Shunt Does the camper have a shunt? ☐Yes ☐ No
List special instructions/Limitations _____

Feminine Needs Does the camper menstruate? ☐ Yes ☐ No
Special treatments for cramps? _____
List feminine products used and if she needs assistance: _____
_____

Participation Please list any activities the camper may NOT participate in or attach precautions or special instructions for routine camp activities: _____
_____
_____

Medical Form & Medication

The completed **2017 Medical Form** or **School Physical Form (dated within the last 12 months)** along with a **CURRENT SHOT RECORD MUST** be received by UCP of DE Camp Lenape Administration Office 30 days prior to the first day of the camp session the camper will be attending. Missing this deadline may result in the camper's reservation being voided and filled by another camper.

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PLEASE TYPE OR PRINT CLEARLY

Camper Name _____

Payment & Financial Information

$130/week for 9am to 3pm session
$145/week for 7am to 6pm session

A non-refundable $25 application fee is due with this application. POC participants do not need to pay this application fee.

If you are unable to afford the full cost of camp, there are other options available. These options include the State of Delaware's Purchase of Care (POC) daycare assistance programs and camperships from the community and organizations. The number to call to see if you qualify for POC is **211 or your social worker**. We will help you through this process.

Please indicate your need for a campership. ☐ YES ☐ NO If yes, please indicate the reason for your need:

_____

_____

Please note that many community organizations require UCP to release to them the name, address, and in some cases the phone number for any child who receives a campership. The information is for the community organization's records and will be kept confidential.

I give United Cerebral Palsy of DE, Inc., permission to release my name, address, and phone number to the organization that provides the campership for my child(ren).

Signature: _____ Date: _____

Schedules

WEEK	PLEASE CHECK THE WEEK(S) YOU PLAN TO ATTEND	CAMP HOURS 7AM – 6PM. PLEASE PROVIDE YOUR ANTICIPATED DROP-OFF & PICK-UP TIMES
JULY 3RD – JULY 7TH (CLOSED ON THE 4TH)		
JULY 10TH – JULY 14TH		
JULY 17TH – JULY 21ST		
JULY 24TH – JULY 28TH		
JULY 31ST – AUGUST 4TH		
AUGUST 7TH – AUGUST 11TH		

Please circle a T-shirt size for camper: **Youth** S M L **Adult** S M L XL 2XL

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PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Waivers & Releases

(1) **Approval, Waiver, and Activity Consent:** This application has my approval. While UCP of DE's, Camp Lenape will take every precaution, it is agreed that UCP of DE's, Camp Lenape is not legally responsible for any accidents, incidents, or injuries that may occur during camp session, assumes no responsibility for applicant's personal property and is released from liability for any accident, incident, or injury except that may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, except noted by myself or physician.

(2) Medical Treatment: The undersigned hereby authorizes and grants permission to any licensed/certified medical or professional designated by UCP of DE's, Camp Lenape to provide routine medical care and administer medications or to perform any emergency procedures on the camper that would be jeopardized by any delay in providing such treatment or performing such procedures.

(3) Media Release: I, the undersigned, hereby authorize UCP of DE's, Camp Lenape, its employees, agents, and assigns to release any pictures or photography taken of the above-named camper for publication for purposes of conveying information concerning the named individual and/or UCP of DE's, Camp Lenape. The undersigned hereby agrees also to hold UCP of DE's, Camp Lenape harmless of liability should such pictures or photographs either accompanied or unaccompanied by printed material, appear in other publications by whomsoever published, circulated, or distributed. I understand that these materials may be published on UCP of DE's, Camp Lenape's network, web sites, and social media.

I attest that all information provided in this application, materials, medical examination summary, and any supplemental items attached are true and correct to the best of my knowledge.

Signature of Legal Guardian/Adult Camper: _____

Date: _____ Printed Name: _____

UCP United Cerebral Palsy of Delaware, Inc.
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NAME_____

BIRTHDATE_____

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

❑ Allergies (food, medicine, bee sting etc.)	❑ Frequent Colds	❑ Fainting	❑ Physical Handicap
	❑ Hearing Difficulty	❑ Speech Difficulty	❑ Behavior Problem
❑ Constipation/Diarrhea	❑ Seizures	❑ Vision Difficulty	❑ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

_____

_____

Parent/Guardian's Signature_____ Date_____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: _____

_____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's Signature_____ ❑ M.D. ❑ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

DOC.NO. 37-06-10-01-01-01

NEW CASTLE COUNTY BENEFICIARY INFORMATION

SELF-CERTIFICATION OF INCOME, RACE, AND ETHNICITY

For CDBG Programs Requiring Information on Income by Family Size

List family members for non-housing programs, household members for housing programs.

*This self-certification for income purposes should be used as a last resort only. Applicants should provide proof of income in accordance with New Castle County's three acceptable forms of income first (Part 5 Annual Income, Census Long Form Annual Income or IRS Form 1040). Head of Household must complete this entire form.

LISTING OF FAMILY/HOUSEHOLD MEMBERS -- For each member over the age of 18, attach income documentation or a certification of zero income.

NUMBER OF FAMILY/HOUSHOLD MEMBERS ____ * ANNUAL FAMILY/HOUSEHOLD INCOME ____
(members over age 18)

NAME _____ Check if over 18 ___ NAME _____ Check if over 18

NAME _____ Check if over 18 ___ NAME _____ Check if over 18

NAME _____ Check if over 18 ___ NAME _____ Check if over 18

NAME _____ Check if over 18 ___ NAME _____ Check if over 18

RACE AND ETHNICITY

This information contained herein is CONFIDENTIAL and will be used only for the purpose as stated below. This information is requested by the Government SOLEY for the purpose of monitoring compliance with Federal anti-discrimination statutes. It is a HUD requirement we collect this information for statistical reporting purposes. **Please check the appropriate boxes below: COMPLETE FOR HEAD OF HOUSEHOLD ONLY.**

Applicant:

Sex: ☐ Female ☐ Male

Ethnicity: (Select *only one*) This is a HUD requirement

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race: (Select *one*) This is a HUD requirement

☐ American Indian or Alaska Native
☐ Asian/Indian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Black or African American & White
☐ Balance Reporting More than One Race

Address:

_____

_____

_____

Agency: Remember to perform parcel search of address. www.needc.org/parcelview

Female Head of Household: ☐ Yes ☐ No

Handicapped Status: ☐ Yes ☐ No

(Handicapped households are those headed by a person who is handicapped. Also included are handicapped persons who are members of non-handicapped households. "Handicapped person" means any person who (I) has a physical or mental impairment which substantially limits one or more major life activities, (II) has a record of such impairment, or (III) is regarded as having such an impairment.)

Under penalty of perjury, I certify that the information presented in this certification is true to the best of my knowledge. I further understand that providing false information on this page constitutes an act of fraud. False, misleading or incomplete information may result in termination of assistance.

_____ _____ _____

Signature of Applicant | Printed Name of Applicant | Date

For Office Use Only:

_____ 0% - 30% of median _____ 31% - 50% of median _____ 51% - 80% of median _____ Over 80% of median

Date of Income Guidelines Used _____