700 A River Road
Wilmington, DE 19809

Dear Camper Family,

Thank you for your interest in United Cerebral Palsy of Delaware's Camp Manito! We are so excited that you are interested in attending Camp Manito. Enclosed you will find the camper application along with forms that are required for the enrollment process.

Camp Manito is a 6 week summer day camp serving children with Cerebral Palsy, Spina Bifida, Muscular Dystrophy, and a spectrum of other disabilities. The camp is also open to children without disabilities, so that all campers interact with their peers in a setting that is inclusive, safe, stimulating, and recreational. **A minimum of one week is required for enrollment**

Please return the completed application along with a photo of your camper to our office by 5/15/17 with a non-refundable $30 application fee. Application fee is payable via check or money order.

Please note that missing information, and incomplete forms will result in the spot being given to a camper that has completed the entire process. There will be a $35 charge for all returned checks.

Here is a helpful checklist with dates: Return to UCP of DE, 700A River Road Wilmington, DE 19809

- Completed application, non-refundable $30 application fee, and photo of camper by 5/15/17
- Completed medical form and shot record by 6/3/17
- New Castle County CDBG form by 6/3/17
- Proof of income 6/3/17
- Behavior Intervention Plan or Individualized Education Plan (if applicable) by 6/3/17

Julie Belford
Administrative Assistant/Camp Administrator
Jbelford@ucpde.org
302-764-2400 (o)
302-764-8713 (f)

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

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

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) ___________________________

____

____

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CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

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 Manito 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 Manito:

☐ Family Member______________________ ☐ Other Camper ______________________
☐ Camp Fair ______________________ ☐ School ______________________
☐ Website ______________________ ☐ Social Service Agency ______________________
☐ Other _____________________________________

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

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name ____________________

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? ____

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

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

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

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Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name ____________________

Payment & Financial Information

$160/week if application received by 5/15/17
$175/week if application received after 5/15/17

A non-refundable $30 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 Manito will take every precaution, it is agreed that UCP of DE's, Camp Manito 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 Manito 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 Manito, 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 Manito. The undersigned hereby agrees also to hold UCP of DE's, Camp Manito 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 Manito'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: ____

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.)
- ❑ Constipation/Diarrhea
- ❑ Frequent Colds
- ❑ Hearing Difficulty
- ❑ Seizures
- ❑ Fainting
- ❑ Speech Difficulty
- ❑ Vision Difficulty
- ❑ Physical Handicap
- ❑ Behavior Problem
- ❑ 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.nccde.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 ____________