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

3249 Midstate Road
Felton, DE 19943

Dear Parent/Guardian and Camper,

Thank you for your interest in United Cerebral Palsy of Delaware's Camp Lenape! We are so excited that you are interested in attending Camp Lenape. Enclosed you will find the camper application along with the essential information to provide you with a smooth registration process.

This is what we will need from you before we can guarantee your camper's enrollment:

- Application
- A non-refundable $30 application fee – Per Family
- IEP and/or BEP
- Health Packet

All items above must be completed in full and returned to Camp by 5/15/18 in order to reserve your camper's spot. Enrollment will be confirmed when completed documentation and application fee has been received and reviewed. You will be contacted if any forms are incomplete or missing. Missing information could only delay your camper being accepted.

Thank you again for your support, and we will see you this summer.

*Carma*

Carma Carpenter
Kent/Sussex Director
ccarpenter@ucpde.org
(o) 302-335-5626 (f) 302-335-5716

# 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: _____ Date of Application: _____

Nickname: _____ Date of Birth: ____/____/_____ Age: _____

Gender (circle one) Female Male Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Please select how you plan to pay for camp ☐ POC ☐ DFS ☐ DDDS ☐ Self-Pay

☐ Other _____ Annual Household Income: _____

## Camper's Health Information

Does the 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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PLEASE TYPE OR PRINT CLEARLY  Camper Name _____

## Parent/Caregiver Information

**1. Custodial Parent/Guardian**: _____

Relation to Camper: _____ Home #: _____

E-Mail Address: _____

Employer: _____ Work#: _____ Cell#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

**2. Custodial Parent/Guardian**: _____

Relation to Camper: _____ Home #: _____

E-Mail Address: _____

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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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)? ☐ Yes or ☐ No
Does the camper have 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 _____

## Payment & Financial Information

**$150/week for 9am to 3pm session**
**$165/week for 7am to 6pm session**

A non-refundable $30 application fee is due with this application, this is per family. 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 program 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,

- A personal statement explaining the reason you need a campership,
- A list of all members living in the household,
- A signed 2017 Tax Return
- Two most recent paystubs from each household earner,
- Documentation for all other income (child support, alimony, benefits, etc.) or a statement that you do not receive additional income.

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 2RD – JULY 6TH (CLOSED ON THE 4TH) | | |
| JULY 9TH – JULY 13TH | | |
| JULY 16TH – JULY 20ST | | |
| JULY 23rd – JULY 27th | | |
| JULY 30th – AUGUST 3rd | | |
| AUGUST 6th – AUGUST 10th | | |

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



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## 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: _____



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# Camp Lenape Health Form 2018

To Parent(s)/Guardian(s):
1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

**Camper Name:** _____

**Camper Address:** _____
**Street Address** **City** **State** **Zip**

**Camper DOB:** _____ **Camper Gender:** ☐ **Male** ☐ **Female**

## Emergency Contacts/Authorized for Pick Up:

| Name (please print) | Pick-Up? | Relationship to Camper | Cell Phone | Work Phone/Other |
|---|---|---|---|---|
| 1. | ☐Yes ☐ No | | | |
| 2. | ☐Yes ☐ No | | | |
| 3. | ☐Yes ☐ No | | | |

**Allergies:** ☐ No Known Allergies
**This camper is allergic to:** ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
**(please describe what the camper is allergic to, include the reaction, medication needed, dosage, and application)**

**Diet/Nutrition:** ☐ This camper has a regular diet ☐ This camper has a special diet or restrictions **(please describe below)**

**Restrictions:** ☐ Full activities, no restrictions: ☐ Restrictions (please describe restrictions)

**Parent/Guardian Authorization for Health Care:**
The health history is correct and accurately reflects the health status of the camper it pertains to. The person described has permission to participate in all camp activities except as noted by me and/or examining physician. If I cannot be reached in an emergency, I hereby authorizes and grant permission to any licensed/certified medical professional designated by UCP of DE to provide medical care, including but not limited to, X-rays, routine tests, and treatment. I hereby give permission for emergency transportation, hospitalization, medication, anesthesia, and/or surgery.

_____ _____ _____
Signature of Parent/Guardian Date Relationship to Camper

******Please provide a photo copy of insurance card FRONT and BACK********

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2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

**Camper Name:** _____

**General Health History:** Please place an **"X"** next to each question that applies to your camper.

**HAS or DOES your camper:**

_____ have any skin problems
_____ had a recent infectious disease
_____Wear glasses/contacts/eyewear
_____ ever had back or joint problems
_____ ever been hospitalized
_____ had mononucleosis during the past 12 months
_____ traveled outside of the country in the past 9 months
_____ have problems with diarrhea/constipation

_____ ever had surgery
_____ had a recent injury
_____ had fainting or dizziness
_____ had seizures
_____ Behavior Problem
_____passed out/had chest paid during exercise
_____ visited the hospital for anaphylaxis
_____have problems with periods/menstruation

_____ have recurrent/chronic illness
_____ had asthma/shortness of breath
_____ have diabetes
_____ had headaches
_____ Speech/Vision/Hearing difficulty

Please explain any questions you marked with an "X" below:

**Camp First Aid**

The following non-prescription medications are supplied by camp and are used on an **as needed basis** to manage illness and injury. Please circle the medications the camper is allowed to receive.

Acetaminophen (Tylenol)
Aloe
Bismuth subsalicylate (Pepto-Bismol)
Calamine Lotion
Cough Drops
Diphenhydramine (Benadryl)
Hydrocortisone 1% Cream
Ibuprofen (Advil, Motrin)
Topical antibiotic cream

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**Camp Lenape Health Form 2018**

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1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

**Camper Name:** _____

**Mental, Emotional, and Social Health:** Check "yes" or "no" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties? ☐ Yes ☐ No
3. Ever been treated for an eating disorder? ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, other)

Please explain "YES" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

6. Does your camper currently have (or had in the past) any major or minor behavioral concerns, such as issues with aggression, control, anxiety, or attachment? ☐ Yes ☐ No

Please explain concerns in the space below:

**What Have We Forgotten to Ask?** Please provide in the space below any additional information about the camper's health (medical, emotional, or mental) that you think is important or may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

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1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

**PARENT/GUARDIAN: COMPLETE THIS SECTION AND GIVE THIS PAGE TO YOUR HEALTH CARE PROVIDER TO BE COMPLETED.**

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date_____
Month/Day/Year

**Physical completed today:** ☐ Yes ☐ No (if "No", date of last physical: _____)
Month/Day/Year

Weight: _____lbs. Height: _____ft._____in Blood Pressure _____/_____

The camper is undergoing treatment at this time for the following conditions: (describe below) ☐ None

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

_____ Scalp/Skin _____ Heart _____ Vision _____ Ear/Nose _____ Lungs _____ Hearing _____ Throat

_____ Abdomen _____ Blood Pressure _____ Eyes _____ Teeth _____ Extremities _____ Neck/Glands

_____ Nervous System

REMARKS AND RECOMMENDATIONS:

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? ☐ Yes ☐ No

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ Yes ☐ No (please provide additional documentation if you answered "yes"

I have reviewed the Health Form and have discussed the camp program with the camper's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

_____ _____
Printed Name of Licensed Provider Signature of Licensed Provider/Date

_____
Office Phone Number

**Please attach a copy of current immunization record**
**This completed for may be faxed to Camp Lenape at 302-335-5716**