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

Camp Lenape
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 – ($15 for each additional sibling)
- IEP and/or BEP
- Health Packet
- Confirmation of Financial Responsibility

**** Application and all documentation need to be sent to one of the following:**

Via Mail:	**Via Fax:**	**Via E-mail:**
UCP of DE, Inc. Attn: Julie 700A River Road Wilmington, DE 19809	302-764-8713	jbelford@ucpde.org

**** Please note of the following changes to this camp season:**

- Camp hours are 9am to 4pm
- We will offer before and after care at additional fees
- We have implemented a late pick up policy
- We have implemented a payment policy

In order for your application to be reviewed, it must be complete, all required documentation must be submitted with the application, and your registration fee must be paid. Deadline for application and paperwork is 5/1/19. This is not a guarantee of acceptance. 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.

Julie

Julie Belford
Camp Administrator
jbelford@ucpde.org
(o) 302-764-2400 (f) 302-764-8713

Revised 1/20/2018

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 ☐ 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
☐ ADD
☐ ADHD
☐ Autism
☐ Behavior Disorder
☐ Bleeding/Clotting Disorder
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Diabetes
☐ Developmental Disorder
☐ Down Syndrome
☐ Epilepsy/Seizure Disorder
☐ 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 Manito:

☐ 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 of the BIP and/or IEP 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

CAMP FEES

- $175/week - this covers the camp day of 9am – 4pm
- A non-refundable application fee is DUE with the application
  - $30 for first application and $15 per additional application
- Before care is available from 8am – 9am. The fee is $25 per week.
- After care is available from 4pm – 6pm. The fee is $50 per week.
- Late pick up fees:
  - If camper is picked up between 6:01pm – 6:14pm a payment of $20 is due
  - Starting at 6:15pm, it is an additional $1 per minute
  - These fees are per camper and due at time of pick up
  - 3 late pick-ups will result in termination
- Tuition is due Monday morning of each week by 9:30am. Late fees will be assessed starting the next day (Tuesday). A daily late fee will be applied in the amount of $20/day. If not paid by Wednesday of that week, camper will not be permitted to return.

Please circle a T-shirt size for camper:

Youth S M L Adult S M L XL 2XL

If you are unable to afford the full cost of camp, you may request a campership.

Please indicate your need for a campership. ☐ YES ☐ NO

****** If yes, please provide the following with your application

- A personal statement explaining the reason you need a campership,
- A list of all members living in the household,
- A signed 2018 Tax Return
- Three 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.

Signature: _____ Date: _____

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Office 302-335-5626 Fax 302-335-5716

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: _____

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: _____

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Life without limits for people with disabilities™

3249 Midstate Road, Felton, DE 19943

Camper Name: _____

Weekly Camp Fee is $175 which covers camp day 9am – 4pm
Before Care Weekly Fee is $25 which covers 8am – 9am
After Care Weekly Fee is $50 which covers 4pm – 6pm

Please notate drop off and pick up times on each day

July 1, 2019	July 2, 2019	July 3, 2018	July 4, 2018 CLOSED – HAPPY 4th of JULY	July 5, 2019	TOTAL DUE (this will be completed by camp)
July 8, 2019	July 9, 2019	July 10, 2019	July 11, 2019	July 12, 2019	TOTAL DUE (this will be completed by camp)
July 15, 2019	July 16, 2019	July 17, 2019	July 18, 2019	July 19, 2019	TOTAL DUE (this will be completed by camp)
July 22, 2019	July 23, 2019	July 24, 2019	July 25, 2019	July 26, 2019	TOTAL DUE (this will be completed by camp)
July 29, 2018	July 30, 2019	July 31, 2019	August 1, 2019	August 2, 2019	TOTAL DUE (this will be completed by camp)
August 5, 2019	August 6, 2019	August 7, 2019	August 8, 2019	August 9, 2019	TOTAL DUE (this will be completed by camp)

PARENT/GUARDIAN SIGNATURE: _____

Revised 1/2019

Summer 2019 Attendance Calendar – CAMP LENAPE

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

3249 Midstate Road, Felton, DE 19943
Voice 302-335-5626 or 302-764-2400

Drop-off/Pick-Up Authorization

The arrival and departure of the children to and from Camp Lenape is the responsibility of the parent/guardian.

Name of Camper _____ DOB _____

Arrival Time _____ Pick Up Time _____

Is Camper utilizing transportation services Yes No If yes, name of transportation service: _____

Please identify whom you authorize to drop-off/pick-up your child. We will not allow a child to leave with anyone not indicated below:

_____
Name Relationship to Camper

_____
Name Relationship to Camper

_____
Name Relationship to Camper

_____
Name Relationship to Camper

I understand that only the above mentioned persons will be permitted to drop-off/pick-up my child, _____, from Camp Lenape. In the case of unusual circumstances, I will call the Camp Administrator with notification of the change. I understand that it is my responsibility and the responsibility of the authorized individuals to properly sign the camper in and out.

_____ _____
Signature of Parent Guardian Date

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Camp Lenape Health Form 2019

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 authorize 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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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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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.

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 form may be returned via fax 302-764-8713, email jbelford@ucpde.org, or mail to UCPDE, 700A River Road, Wilmington, DE 19809.
Any questions, please call Julie at 302-764-2400.