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
- If any of the above documentation is missing or incomplete, the application will be put on hold. A spot will not be held.

- Camp Hours are 8:00am to 4:00pm, the fee is $175/week
- After Care is available from 4:00pm to 6:00pm, the fee is $50/week

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

** Via Mail:**
UCP of DE, Inc.
Attn: Julie
700A River Road
Wilmington, DE 19809

** Via Fax:**
302-764-8713

** Via E-mail:**
jbelford@ucpde.org

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 1/2020
United Cerebral Palsy of Delaware, Inc.'s
Camp Lenape

Date: July 6—August 14, 2020
Monday—Friday
Camp Day: 8:00am—4:00pm $175/week
After Care: 4:00pm—6:00pm $50/week

Location: United Cerebral Palsy of DE
3249 Midstate Road
Felton, DE 19943

Activities Include:
Arts & Crafts
Sports
Swimming (In-Pool Ramps)
Lunch & Snack Included

Accepting children ages:
3-21 with disabilities &
Children ages:
5-13 without disabilities

Volunteers Always Welcome!

Please Contact:
Julie Belford
jbelford@uepde.org
302-764-2400

Applications available
on website at:
www.uepde.org
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 □ Intellectual Disabilities
□ Asthma □ Mild □ Moderate □ Severe/Profound
□ ADD □ Learning Disability
□ ADHD □ Muscular Dystrophy
□ Autism □ Psychosis
□ Behavior Disorder □ Speech-Language/Voice Dysfunction
□ Bleeding/Clotting Disorder □ Non Verbal
□ Cerebral Palsy □ Spina Bifida
□ Cystic Fibrosis □ Spinal Cord Injury
□ Diabetes □ Quadruplegic □ Paraplegic □ Other
□ Developmental Disorder □ Social/Psychological
□ Down Syndrome □ Visual Impairment
□ Epilepsy/Seizure Disorder □ Partial □ Total
□ Hearing Impaired □ Other Disability(s) ____________________________

□ Partial □ Total
□ Heart, Circulatory, Respiratory Defect

______________________________________________________________
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

Page 2 of 6
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
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? ____________________________________________
Payment & Financial Information

CAMP FEES

▲ $175/week - this covers the camp day of 8am – 4pm
▲ A non-refundable application fee is DUE with the application
  o $30 for first application and $15 per additional application
▲ After care is available from 4pm – 6pm. The fee is $50 per week.
▲ Late pick up fees:
  o If camper is picked up between 6:01pm – 6:14pm a payment of $20 is due
  o Starting at 6:15pm, it is an additional $1 per minute
  o These fees are per camper and due at time of pick up
  o 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,
• 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: ___________________
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: _______________________________
Weekly Camp Fee is $175 which covers camp day 8am – 4pm
After Care Weekly Fee is $50 which covers 4pm – 6pm

COMPLETE EACH BOX THAT CAMPER WILL BE ATTENDING WITH TIMES

<table>
<thead>
<tr>
<th>July 6, 2020</th>
<th>July 7, 2020</th>
<th>July 8, 2020</th>
<th>July 9, 2020</th>
<th>July 10, 2020</th>
<th>TOTAL DUE (this will be completed by camp)</th>
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<tr>
<td>July 13, 2020</td>
<td>July 14, 2020</td>
<td>July 15, 2020</td>
<td>July 16, 2020</td>
<td>July 17, 2020</td>
<td>TOTAL DUE (this will be completed by camp)</td>
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<tr>
<td>July 20, 2020</td>
<td>July 21, 2020</td>
<td>July 22, 2020</td>
<td>July 23, 2020</td>
<td>July 24, 2020</td>
<td>TOTAL DUE (this will be completed by camp)</td>
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<td>July 27, 2020</td>
<td>July 28, 2020</td>
<td>July 29, 2020</td>
<td>July 30, 2020</td>
<td>July 31, 2020</td>
<td>TOTAL DUE (this will be completed by camp)</td>
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<tr>
<td>August 3, 2020</td>
<td>August 4, 2020</td>
<td>August 5, 2020</td>
<td>August 6, 2020</td>
<td>August 7, 2020</td>
<td>TOTAL DUE (this will be completed by camp)</td>
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<tr>
<td>August 10, 2020</td>
<td>August 11, 2020</td>
<td>August 12, 2020</td>
<td>August 13, 2020</td>
<td>August 14, 2020</td>
<td>TOTAL DUE (this will be completed by camp)</td>
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</tbody>
</table>
Camp Lenape Health Form 2020

Camper Name: ________________________________

Camper Address: ____________________________________________

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Camper DOB: ____________________ Camper Gender: □ Male □ Female

Emergency Contacts/Authorized for Pick Up:

<table>
<thead>
<tr>
<th>Name (please print)</th>
<th>Pick-Up?</th>
<th>Relationship to Camper</th>
<th>Cell Phone</th>
<th>Work Phone/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>□ Yes □ No</td>
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<tr>
<td>2.</td>
<td>□ Yes □ No</td>
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<td>3.</td>
<td>□ Yes □ No</td>
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</tbody>
</table>

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*****

Page 1 of 4
12/18/19
Camp Lenape Health Form 2020

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  ___ ever had surgery  ___ have recurrent/chronic illness

___ had a recent infectious disease  ___ had a recent injury  ___ had asthma/shortness of breath

___ Wear glasses/contacts/eyewear  ___ had fainting or dizziness  ___ have diabetes

___ ever had back or joint problems  ___ had seizures  ___ had headaches

___ ever been hospitalized  ___ Behavior Problem  ___ Speech/Vision/Hearing difficulty

___ had mononucleosis during the past 12 months  ___ passed out/had chest pain during exercise

___ traveled outside of the country in the past 9 months  ___ visited the hospital for anaphylaxis

___ have problems with diarrhea/constipation  ___ have problems with periods/menstruation

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

---

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.
Camp Lenape Health Form 2020

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.
Camp Lenape Health Form 2020

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 jbfeldor@ucpde.org, or mail to UCPDE, 700A River Road, Wilmington, DE 19809.

Any questions, please call Julie at 302-764-2400.

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