

DREAM OAKS CAMP PAYMENT OPTION FORM SUMMER 2008

Please select the camp that would best fit your child's needs. Space is limited and each camp is filled on a first come first serve basis. Please select the camp(s) you would like your camper to be considered for. Place a "1" in the box as your first choice and a "2" in the box for your second choice, etc. A wait-list has been created if you have a third or more request as we hope to give all children a chance to enjoy Dream Oaks Camp. We will notify you at least one week before the wait-listed camp session if we have the space to fulfill your request.

June 16-20, 2008	_____	Session #1 Day Camp – All Disabilities
June 16-20, 2008	_____	Session #1 Residential – All Disabilities
June 23-27, 2008	_____	Session #2 Residential – Autism, Aspergers, PDD
June 30-July 4, 2008	_____	Session #3 Residential – All Disabilities
July 7-11, 2008	_____	Session #4 Residential – Physical Disabilities
July 14-18, 2008	_____	Session #5 Residential – Sibling / All Disabilities
July 21-25, 2008	_____	Session #6 Residential – Developmental Delays
July 28-Aug 1, 2008	_____	Session #7 Residential – ADD, ADHD or Learning Disabilities

Camper's Name _____

Contact Person _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

The cost for attending a Dream Oaks Camp summer session is: **Day Camp - \$400.00 Residential Camp - \$650.00.**

Please check one of the four payment options and return with the application.

_____ **OPTION 1** – I have included payment in full for the summer camp session(s) the camper is scheduled to attend. I understand that to reserve a space in the camp session payment is due prior to attendance.

_____ **OPTION 2** – I have included the \$50 deposit each for the summer camp session(s) the camper is scheduled to attend. I understand that to reserve a space in the summer camp session payment is due prior to attendance.

_____ **OPTION 3** – I have secured sponsorship for the camp session fee through _____
 _____ (Agency or Organization) for the amount of \$_____. My contact at the organization is
 _____ and the phone number is _____.

_____ **OPTION 4** – I would like to be considered for Financial Assistance (please complete the highlight bottom section of page 1 of the Dream Oaks Camp Application and include your most recent W-2 or tax return with application).

If Option 3 or 4 is checked, a \$50 deposit is still required with your application. Please contact us for more information or assistance if necessary.

Payments can be made via Credit Card

Amount to be paid \$ _____

Type of Card: _____ Visa _____ MasterCard _____ American Express

Card Number: _____

Issued to: _____

Expiration Date: _____

Name as it appears on card: _____

Checks & Money Orders can be made out and sent to:

Foundation for Dreams, Inc.
7359 Merchant Court
Sarasota, FL 34240
 (941) 907-1111

Foundation for Dreams, Inc. Dream Oaks Camp Application 2008

Mail to: Camp Director, Foundation for Dreams, Inc., 7359 Merchant Court, Sarasota, FL 34240 with a \$50 non-refundable registration fee to hold desired camp date. For Questions call: (941) 907-1111 fax: (941) 907-1112

Camper's Last Name	First	(Nickname)	Birthdate: _____	Age: _____
			(Day/Month/Year)	
Address			City	
State		Zip	County	
#1 Parent/Guardian Last Name: _____			First Name _____	
Home Phone: () _____		Cell Phone: () _____	Email: _____	
Place of Employment: _____			Work phone: () _____	
#2 Parent/Guardian Last Name: _____			First Name _____	
Home Phone: () _____		Cell Phone: () _____	Email: _____	
Place of Employment: _____			Work phone: _____	
Camper lives with: Mother / Father / Both Parents /Guardian Contact information (if different) _____				

Camper's Disabilities/Medical History (include primary diagnosis/surgeries, etc) _____

Male Female Ht: _____ Wt: _____ Ethnicity _____ T-Shirt size: _____

If parent/guardian will be away from home during camp **You must have a local contact person who could pick up your child in your absence.** Name of Friend or Relative to notify in case of emergency and unable to contact parent/guardian:

Name _____ Phone # _____ Relationship: _____

Tuition Costs: Weekend: \$200 Day Camp: \$400 Residential \$650		
If you would like to be considered for Financial Assistance this section <u>must</u> be filled out completely. Also attach a copy of the most recent years W-2's or Income Tax form. Tuition assistance is determined according to sliding scale and could include the full or partial amount of tuition less the registration fee for each session.		
County of Residence _____	# of People living in Home: _____	Annual Household Income: _____
Any special circumstances?	Office use only:	

1. Does Camper walk independently? Yes No
 Does Camper use (Circle) crutches walker electric wheelchair manual wheelchair
 Need assistance with transfers? Yes (Circle one) Partial or Total No
 Wear braces? Yes No
 Use a lift to transfer? (Hoyer lift, etc.) Yes No
 • **If lift is used at home and or the camper is over 180 lbs and cannot assist with transfer, lift must be brought to camp!**

2. Camper's Sleep Habits: (Check and add comments)
- Sleepwalks or wanders at night Yes No _____
 Restless or light sleeper Yes No _____
 Nightmares Yes No _____
 Afraid of dark Yes No _____
 Takes regular naps during day Yes No _____
 Does Camper sleep through the night? Yes No _____
 Has Camper slept away from home before? Yes No _____
 Is Camper able to sleep in the upper bunk? Yes No _____
 Does Camper need bed rails or other special night care? Yes No If yes, please specify: _____

(NOTE: If Camper stays awake at night & sleeps during the day or disturbs others, Camper may be sent home.)

3. Meals at Camp:
- Appetite is generally (Circle) Excellent Average Fair Poor
 Requires limited portions Yes No _____
 Special Diet Yes No Explain _____
 Assistance with feeding / eating Yes No Explain _____
 Food Allergies: Yes No If yes, please specify: _____
 (Please provide list of restricted foods or substitutions.)
 Does food need to be pureed? Yes No _____
 Please describe any needed help, special utensils, etc. _____

4. Camper's Dressing Skills: (Check and Describe)
- Camper fully dresses self without assistance Yes No _____
 Camper needs minimal assistance Yes No _____
 Camper mostly dresses with verbal prompts Yes No _____
 Camper needs full assistance to dress Yes No _____

5. Toileting Skills: (Check and Describe)
- Does Camper need assistance in toileting? Yes No If yes, please describe routine: _____

 Does Camper wet bed? Yes No If yes, how often _____
 Is Camper easily constipated? Yes No _____
 Does camper wear diapers? Yes No Day _____ and / or Night _____
 • **If yes, please send ample supply of disposable ones and pull-ups for the pool.**
 Does Camper have accidents with bladder and bowel control? Yes No
 Does Camper use a foley catheter? Or urinary bag? Yes No
 If yes, please state details _____

6. Is Camper's mental age below the actual age? Yes No Is Functional age below? Yes No
 If so, what is his/her approximate mental age? _____ Functional Age? _____
7. Does Camper have seizures? Yes No
 Seizure type _____
 Frequency _____
 Date of last seizure _____
 List any special emergency care for seizures _____
8. Does Camper have a cardiac condition? Yes No If yes, list care and limitations _____

9. Does Camper have allergies? Yes No
 If yes, list special equipment required to alleviate this condition _____
10. Does Camper fatigue easily? Yes No
11. Does Camper have any severe respiratory problems? Yes No
 If yes, list special equipment required to alleviate this condition _____
12. Does Camper wear glasses? Yes No
13. Does Camper have hearing difficulty? Yes No
 If yes, to what degree? _____
 Does Camper wear a hearing aid or cochlear implant? Yes No
14. Does Camper have a speech difficulty? Yes No _____
 Camper may be difficult to understand Yes No _____
 Carries on clear conversation Yes No _____
 Limited Speech Yes No _____
 Is Non-Verbal Yes No _____
 Understands simple speech Yes No _____
 Uses ASL or simple signs Yes No _____
15. May Camper participate in the following programs:
 Swimming? Yes No
 • Swimming ability: (circle) None Wading Beginning Intermediate Advanced
 Hiking? Yes No
 Horseback Riding? Yes No
 Overnight camp-out, with bedding on the ground? Yes No
16. Are there any precautions you wish to have observed at Camp? If so, please describe and be specific: _____

17. Has Camper been separated from the family before?
 If yes, how did Camper react _____
18. Does Camper wander? Yes No _____
19. Has Camper ever run away from home / school? Yes No _____
20. Does Camper have self-injurious behaviors? Yes No _____
21. Does Camper have unusual fears? Yes No _____

22. What types of behaviors is Camper apt to exhibit when he/she is unhappy? _____

23. Is a **Behavior Management** plan/program (or intervention plan) being used with camper? Yes No
If yes, a copy must be sent in with this application.

24. How do you deal with Camper's behaviors? Please describe positive reinforcements, and things or activities that are calming or rewarding for Camper. _____

25. Please list all camps or after school programs the Camper has participated in previously: _____

26. Any previous problems or concerns at camp? Yes No Please describe date and situation: _____

27. Does Camper have favorite activities? Hobbies? _____

28. Does Camper have dangerous tendencies that could result in harm to self, other campers or staff? Please describe: _____

- (NOTE: If Campers needs/behaviors do not meet eligibility guidelines/code of conduct, Camper will be sent home)

29. Does Camper require one-to-one supervision while at camp? Yes No
(Not physical care but constant supervision to assure safety of camper and others)
(If 1:1 care is needed, Camper must be accompanied by aide, nanny, etc.)
Camper needs 1:1 supervision for _____

30. Please tell us anything about Camper and home life that you think would help Camper feel at ease and have fun at camp and / or provide any additional information you feel is necessary: _____

• If you feel that your camper has exceptional needs or complications that go beyond the scope of this form and you would feel more comfortable speaking directly with us, please feel free to call. If you have failed to notify us of the severe needs of your camper and this causes us to exceed the number of campers to whom we can provide care, your camper will be sent home.

ACCEPTANCE CONDITIONS:

Dream Oaks Camp reserves the right to refuse to provide services to any individual when the camp staff determines that the individual cannot be provided with adequate support by Dream Oaks Camp. These decisions are made on an individual basis, by the Camp Director, Nurse and/or the Chief Operating Officer of the Foundation for Dreams, Inc.

Parents/guardians will be notified in the event of any serious injury or illness requiring more than basic first aid, or in the case of any significant incident or behavioral problem. The separate Health Examination Form, signed by a physician, M.D., must indicate that there is no evidence of any condition that might present health or safety risks to the applicant, or to other campers or staff members.

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN YOUR NAME BELOW.

I agree to the Acceptance Conditions above. Should it become necessary for my camper to leave camp, or any Dream Oaks Camp function, for any reason, I will make provisions to bring the camper home. I hereby certify that to the best of my knowledge, all of the information contained in this application is true and complete.

I hereby authorize the release of any and all pertinent information regarding this camper to Dream Oaks Camp. I agree to notify Dream Oaks Camp of any changes that need to be made in this application before camp.

Signature _____

Relationship to Camper _____

Date _____

PARENTS CONSENT FORM

ASSUMPTION OF RISK: I, the undersigned parent or guardian of the below named camper, who desired to participate in activities at camp offered and organized by Dream Oaks Camp, hereby acknowledge that I am aware that there are significant risks associated with participation in camp, including, without limitation, the risk of serious bodily injury or death. On behalf of myself, my spouse and camper, and our respective heirs, administrators, representatives and successors, I willingly assume such risks. By signing this document I am providing a clear, written expression of my agreement to assume all of the risks and dangers my camper may encounter at camp, and to never sue or make a claim against Dream Oaks Camp, the Foundation for Dreams, or any of its employees or agents.

RELEASE AND WAIVER: In consideration of the permission granted by Dream Oaks Camp for _____ (camper) to participate in activities at camp the undersigned hereby agrees to release and discharge the organization, its officers, agents and employees from all claims, demands, actions or causes of action, which the camper, his or her personal representatives, heir and next of kin, may or might have against Dream Oaks Camp, the Foundation for Dreams, its officers, agents and employees on account of injury to or death of the camper, or damage to the property of the camper arising out of the camper's participation in activities at camp. The undersigned further agrees to indemnify and hold harmless Dream Oaks Camp and the Foundation for Dreams from any loss, liability, damage or costs that may be incurred due to the acts of the camper during the camper's participation in activities at camp.

PHOTOGRAPHIC RELEASE: The undersigned does hereby give consent to Dream Oaks Camp and Foundation for Dreams, to photograph camper and, without limitation, to use such picture and/or stories in connection with any of the work of said Dream Oaks Camp and Foundation for Dreams without consideration of compensation of any kind, and does hereby release said Dream Oaks Camp and Foundation for Dreams from any claims whatsoever which may arise in said regard. Yes No

PERSONAL PROPERTY: The undersigned recognizes that Dream Oaks Camp cannot accept responsibility for camper's personal property. To help eliminate losses, the undersigned has ensured that ***all clothing is labeled with camper's name and a list of belongings has been included in luggage.***

(continued on next page)

(consent form continued from previous page)

MEDICAL RELEASE: In the event that an emergency should arise while _____ (camper) is at camp, going or returning from, requiring medical or surgical care or treatment, the undersigned authorizes camp staff and Dream Oaks Camp to select and designate nurses, physicians, and surgeons to furnish such medical and/or surgical care as, in the judgment of a physician and/or surgeon holding a physician's certificate issued by the Board of Medical Examiner's of the State of Florida, may be needed and proper. I authorize camp staff and Dream Oaks Camp to render any aid and assistance to my camper, and to administer medication to my camper. I authorize the camp medical staff to dispense medications. I agree that medications for life threatening conditions (e.g., bee sting medications, inhaler), will be carried by a camp staff person and I authorize their use for my camper as needed. I agree to pay for any prescribed medication or treatment my camper may need. The undersigned releases and absolves Dream Oaks Camp, the Foundation for Dreams, and nurses, physicians, and surgeons selected and designated by them, from any and all liability for their acts rendered in good faith. Parents / Guardians will be notified within 24 hours of any treatment sought.

CHECK-OUT PROCEDURES: Camp staff will not release any camper to anyone other than the parent or guardian without prior written authorization.

Remember to confirm check-out time on the last day.

I authorize Dream Oaks Camp staff to release this camper to the following person(s):

NAME Relationship to Camper

NAME Relationship to Camper

Please sign below to acknowledge consent to all conditions above:

BOTH PARENTS' SIGNATURES REQUIRED or (SINGLE PARENT/GUARDIAN WITH LEGAL CUSTODY):

Please specify your relationship: MOTHER FATHER GUARDIAN DATE

Please specify your relationship: MOTHER FATHER GUARDIAN DATE

Foundation for Dreams
Dream Oaks Camp

Acknowledge and Release to Manatee County Government

I, _____, (Parent or guardian signature), hereby acknowledge and release to Manatee County Government, my child's records which may be required by the County for purposes of monitoring and evaluating services. I understand Agency records relating to this program may be public records under Chapter 119, Florida Statutes.

Child's/Camper's Name _____

Parent/Guardian Signature _____ Date _____

Acknowledge and Release to State of Florida Department of Children and Families

I, _____ (Parent or guardian signature), hereby acknowledge and release to the State of Florida, my child's records which may be required by the State of Florida for purposes of monitoring and evaluating services. I understand Agency records relating to this program may be public records under Chapter 119, Florida Statutes.

Child's/Camper's Name _____

Parent/Guardian Signature _____ Date _____

Dream Oaks Camp Health Examination

DATE _____

Campers Name _____

Parents Name _____

Mail To:
Foundation for Dreams, Inc.
7359 Merchant Court
Sarasota, FL 34240
(941) 907-1111
Fax: (941) 907-1112

This Health Examination Form for Camp must be completed by the parent/guardian and physician at the time of examination and must be received by the camp office no later than 15 days prior to the camp session.

A physician must personally examine all campers within 1 year of camp attendance date

DOB: _____ Age: _____ Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____ BP _____

Immunization Up-to-date: Yes: _____ /No: _____ Reason: _____

Date of Last Tetanus Booster: _____ ****Attach copy of Immunization Record for Camper File****

PLEASE NOTIFY US IF CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASE OR HEAD LICE DURING THE THREE WEEKS IMMEDIATELY PRIOR TO CAMP ATTENDANCE.

Diagnosis/Significant Health History: _____

Recent Illness/Hospitalization or Surgery, date and explanation: _____

Medication Allergies: _____

Environmental Allergies: _____

Treatment for Allergic Reaction: _____

Seizure Activity: Yes _____ No _____ Date of last seizure: _____ Seizure type and frequency: _____

Diabetes: Yes _____ No _____ Type: _____ Treatment: _____

Asthma: Yes _____ No _____ Treatment: _____

Special instructions regarding activities the Camper cannot participate in or has limitations? _____

Any health or safety risk to self, or to other campers or staff? Explain: _____

Medication Orders to be given by Camp Nurse (including prn, herbal, and over the counter): Please print

	Name of Medication:	Dosage:	Frequency:	Route:
1				
2				
3				
4				
5				
6				
7				
8				

***Camper is required to bring ample supply of all medications and any new prescriptions to camp. All medicines **MUST BE PRESCRIBED** and **in their original containers** (including vitamins and herbs) and will be administered according to the doctor's above written instructions. **If this page is not completed or there is no attached prescription, then medicine will not be administered by camp nurse.**

(Must be completed by physician in its entirety)

* * * * *

I have examined _____, and reviewed his/her health history.
(Camper's Name)

In my opinion this Camper is physically able to engage in camp activities, except as noted. Medications to be given by Camp Nurse as prescribed and directed above.

EXAMINING PHYSICIAN: _____
(Please type or print name)

Street _____ City _____ State _____ Zip _____
Telephone: (____) _____

Signature of Examining Physician and OFFICE STAMP **Date**

THIS FORM MUST BE SIGNED & DATED BY PHYSICIAN WITHIN 1 YEAR OF CAMP ATTENDANCE

Name of Camper's Medical Insurance _____

Group Number: _____

****Attach a copy (front & back) of all current Insurance & prescription cards. ****