

## Step #1

# EASTER SEALS CAMP FAIRLEE

Easter Seals Delaware and Maryland's Eastern Shore

22242 Bay Shore Rd. Chestertown, MD 21620

Voice 410-778-0566 Fax 410-778-0567

Email: Fairlee@esdel.org Web: www.de.easterseals.com/fairlee

## RESPITE WEEKEND APPLICATION FORM

### Participant Information (Please print clearly or type)

First Name	Last Name	<input type="checkbox"/> New Participant	<input type="checkbox"/> Returning Participant
Address			
City	State	Zip	County
Birthdate	Age		
Male/Female	Height	Weight	
Ethnic Origin (Optional-please check one) <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other			

### Parent Guardian Care Provider Information (Please check one)

Name		
Home Phone	Cell Phone	Work Phone
Email Address:		
Emergency Contacts		
Name	Relationship	
Home Phone	Cell Phone	Work Phone
Name	Relationship	
Home Phone	Cell Phone	Work Phone

### 2017-2018 Respite Weekend Dates

Please select session(s) the participant wishes to attend. Slots are available on a first come first served basis.

<input type="checkbox"/> September 22-24, 2017	Multiple Sclerosis	All ages	15 openings
<input type="checkbox"/> October 20-22, 2017	Autism	All ages	12 openings
<input type="checkbox"/> October 27-29, 2017	Adult 3:1	Adult	20 openings
<input type="checkbox"/> December 8-10, 2017	Youth/Adult	All ages	20 openings
<input type="checkbox"/> February 16-18, 2018	Youth/Adult	All ages	20 openings
<input type="checkbox"/> March 9-11, 2018	Autism	All ages	12 openings
<input type="checkbox"/> March 23-25, 2018	Youth/Adult	All ages	20 openings
<input type="checkbox"/> April 13-15, 2018	Autism/1:1	All ages	12 openings
<input type="checkbox"/> May 4-6, 2018	Multiple Sclerosis		15 openings

The fees for respite weekends: **3:1** supervision is **\$575.00**. For participants requiring **1:1** supervision, the fee is **\$725.00**. (Each weekend will have available 1:1 openings. You must call for approval before registering.) Acceptance is based upon staff availability.

Participants that use Maryland Autism Waiver Program will need 30 hours per weekend added to their Plan of Care. (You must contact your Service Coordinator and have the Plan of Care submitted to Camp prior to coming.) The Plan can be faxed or emailed to camp separate from the registration.

**Referral Information \*\*Please complete....even if you are a returning participant.\*\***

Name of Teacher/Caseworker/Coordinator:

Agency:

Address:

Phone:

**PAYMENT INFORMATION AND OPTIONS. Please check all that apply. This section must be completed and signed.**

- Choice 1: Full Payment Enclosed
- Choice 2: \$50 deposit enclosed
- Choice 3: Paying by credit card. (Visa, MasterCard, Discover, and American Express) Please call with card information.
- Choice 4: Paying balance monthly. (Must be confirmed with Administration and Director)
- Choice 5: Autism Waiver (A copy of your Plan of Care must be submitted to Camp with the number of hours needed.)

Amount Enclosed \$ \_\_\_\_\_ Balance left to be paid \$ \_\_\_\_\_

Signature of individual responsible for payments/balance \_\_\_\_\_

We encourage you to contact clubs, businesses, organizations and agencies for funding assistance. Please note: If a funding source is paying your deposit and or balance, a completed **Letter of Intent must be on file**.

- Choice 6: Balance to be paid by an agency or organization. (Please complete information below.) \$ \_\_\_\_\_
- Choice 7: Deposit and balance to be paid by an agency or organization. (Please complete information below.) \$ \_\_\_\_\_

Agency/Organization Name \_\_\_\_\_ Contact Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

**WAIVER AND RELEASE (Applications will not be accepted without a signature.)**

**This document must be signed** by either the parent or legal guardian if applicable. All references to the participant include the parent or legal guardian.

As a condition of participation in the summer camp program, the participant agrees to the following:

Participant acknowledges that a wide variety of activities will be conducted, including swimming. Participant acknowledges that some of the activities may subject him/her to certain stresses and hazards not all of which can be foreseen. Participant desires and consents to take part in all such activities unless otherwise indicated in writing prior to the summer camp program. Participant assumes all the risks incident to the nature of the activities to be conducted and agrees that neither Easter Seals Delaware and Maryland's Eastern Shore, nor any of its representatives shall be held responsible for any damages or injuries resulting to the participant in the program. In the event the program staff determine that the participant cannot meet the program eligibility requirements the participant may be dismissed. Supervision and transportation resulting from dismissal of such participant are the responsibility of the participant.

Participant understands that Easter Seals and its representatives are not responsible for loss or damage to the personal property and possessions of the participant.

Participant is liable for any damage to the property of Easter Seals resulting from the acts of the participant.

Participant consents to the use of any film/photographs/video taken during the program, whether for advertising, promotion and/or publicity purposes by Easter Seals unless otherwise indicated in writing prior to the program. The participant waives all claims of compensation for such use.

Permission is granted for participant to attend all program field trips, participant acknowledges that transportation may be provided for program related purposes in a vehicle provide by Easter Seals and its representatives. It is the participants responsibility to adhere to all safety requirements (using seat belts and remaining seated).

Participant represents that all of the information provided in this application, including the health forms, is true and correct and that Easter Seals and its representatives have full right and authority to rely on the information contained therein. Participant further recognizes that Easter Seals and its representatives reserve the right to reject any participant in the event of the failure or refusal of the participant to accurately complete and sign all of the required documents.

**I have read and fully understand the program details, waiver and release.**

Signature of Parent/Guardian

Date

## **Ratio Descriptions**

### **3:1 Ratio**

This ratio applies to participants who need minimal, occasional or no assistance from staff, such as verbal prompts, reminders, or gestures during their daily camp schedule. Participants must be ambulatory and can walk independently or use a wheelchair and can transfer independently or with minimal assistance. Participants must also follow directions of their assigned staff on a regular basis, participate in activities on a regular basis with no disruptive behaviors and sleep at night in a group setting.

### **1:1 Ratio**

This ratio applies to participants who needs constant supervision and individual assistance such as verbal prompts, reminders, gestures, schedules, hand over hand assistance during their daily schedule as well as meals and morning/night routines. Participants can be ambulatory or use a wheelchair and bear weight or need full assistance from the staff such as a 1 , 2 ,3 person transfer or hoyer lift. This also applies to the participant that has a history or current history of disruptive behaviors such as aggression to self or others, elopement, non-compliance, inappropriateness, sleeping issues or any behavior that could be considered disruptive to self or others. Participants who do not attend planned camp activities on a regular basis, require hourly health services such as tube feedings, overnight tub feedings or other health treatments that must be given by a nurse periodically throughout the day will also be considered 1:1.

**LETTER OF INTENT FOR FUNDING**  
**for**  
**Easter Seals Camp Fairlee**

By completing this, your organization, agency, or group has agreed to provide funding for the participant named below, who will be attending Easter Seals Camp Fairlee during the time frame listed below.

Organizations, agencies, and groups such as yours, are vital in helping people with various disabilities enjoy the independence that a summer camping experience can provide. If you require any further information, please do not hesitate to contact us directly.

If you are using the Autism Waiver you **do not** need to complete this form.

Please make sure this form is filled out completely. Mail or fax as soon as possible to our **Administrative Assistant** at: Camp Fairlee, 22242 Bay Shore Rd., Chestertown, MD 21620. Phone: (410) 778-0566. Fax: (410) 778-0567. Our Federal ID number is 51-0066728.

**Participant Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Camp Session Date/s** \_\_\_\_\_

**Amount of Funding Requested \$** \_\_\_\_\_

**This section must be completed and signed by the Organization/Agency/Group authorizing payment.**

The following Organization, Agency or Group has agreed to provide funding in the amount of \$ \_\_\_\_\_ for the above participant who will be attending Easter Seals Camp Fairlee.

Organization/Agency/Group Name: \_\_\_\_\_

Organization/Agency/Group Contact: \_\_\_\_\_

Organization/Agency/Group Address: \_\_\_\_\_  
\_\_\_\_\_

Organization/Agency/Group Phone: \_\_\_\_\_

Signature of Authorizing Contact: \_\_\_\_\_

Payment Enclosed       Please send invoice to Organization at the above address.

Checks can be made payable to: **Easter Seals Camp Fairlee**  
**On behalf of the people we serve, Camp Fairlee thanks you for your support.**



# PARTICIPANT INFORMATION

## Participant Information (Please print clearly or type.)

Name	Last Name	Nickname
<b>Disability Information:</b> Please check the primary and <u>underline</u> all that apply.		
<input type="checkbox"/> Speech-Language <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Peripheral Nerve Injury/Disorder <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Central Nervous System Injury/Disorder Stroke Epilepsy/Seizure Disorder Multiple Sclerosis Head Injury Spinal Cord Injury	<input type="checkbox"/> Neurological Condition(s) at Birth Cerebral Palsy Down Syndrome Spina Bifida <input type="checkbox"/> Social/Psychological Autism Behavior Alcohol/Drug Disorders Psychosis <input type="checkbox"/> Learning/Developmental Delay <input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Orthopedic Impairments at Birth <input type="checkbox"/> Postural Disorders <input type="checkbox"/> Heart, Circulatory, Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Skin and Cellular Tissue Disorder <input type="checkbox"/> Allergic/Metabolic/Nutritional <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Geriatric Aging <input type="checkbox"/> Other Disabilities (please list)
Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe/Profound		

## General Background: Please check all that apply.

<b>Communication</b> <input type="checkbox"/> Speaks Clearly <input type="checkbox"/> Uses Sign Language <input type="checkbox"/> Speaks may difficult to understand <input type="checkbox"/> Uses communication board <input type="checkbox"/> Gestures <input type="checkbox"/> Other: _____	<b>Vision</b> <input type="checkbox"/> Normal <input type="checkbox"/> Mild/Moderate Loss <input type="checkbox"/> Severe/Total Loss Does participant wear corrective lenses? <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Mobility</b> <input type="checkbox"/> Walks independently <input type="checkbox"/> Walks with assistance <input type="checkbox"/> Walks with cane/crutches/walker <input type="checkbox"/> Walking ability affected, but walks independently <input type="checkbox"/> Uses Wheelchair Manual <input type="checkbox"/> Power <input type="checkbox"/> Uses AFO'S
Language Spoken/Understood _____		

## Personal Care Please check all that apply, and provide a complete description if participant requires assistance.

Task	Independent	Requires Some Assistance	Requires TOTAL Assistance	Description of Assistance Needed
Dressing				
Showering				
Teeth Brushing				
Shaving				
Transferring				
Menstruation				
Staff Support		<input type="checkbox"/> 1:1 <input type="checkbox"/> 3:1		
Bathroom Assistance Needed		<input type="checkbox"/> No Assistance <input type="checkbox"/> Partial Assistance	<input type="checkbox"/> Total Assistance	
Aids Used (check all that apply)		<input type="checkbox"/> Diapers <input type="checkbox"/> Bedpan <input type="checkbox"/> Urinal <input type="checkbox"/> Toilet Chair		
Bladder Control		<input type="checkbox"/> Normal <input type="checkbox"/> Has Accidents <input type="checkbox"/> Incontinent	<input type="checkbox"/> Wets bed	
Bowel Control		<input type="checkbox"/> Normal <input type="checkbox"/> Has Accidents <input type="checkbox"/> Incontinent	<input type="checkbox"/> Colostomy	
Eating Assistance		<input type="checkbox"/> No Assistance <input type="checkbox"/> Partial Assistance <input type="checkbox"/> Total Assistance	<input type="checkbox"/> Can feed self finger foods	

What adaptive devices are used for eating? (must be sent to camp) \_\_\_\_\_

Does participant have difficulties swallowing:  Solids  Liquids  or Uses a Straw

Does participant have any known food allergies or problems with foods? \_\_\_\_\_

## Additional Information

Has the participant previously attended a residential camp?  Yes  No

If Yes, what Camp: \_\_\_\_\_

If Yes, was it a positive experience?  Yes  No

If No, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the participant follow direction?  Yes  No  Occasionally

If No or Occasionally, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the participant have any behaviors of which the staff need to be aware?  Yes  No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there key actions, words, or phrases used to stop behavior and redirect?  Yes  No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is a behavior management plan currently being used with the participant?  Yes  No

If Yes, please send a copy with the application. Easter Seals prohibits most restrictive behavior intervention techniques. Acceptance will be based on our ability to follow plans within agency policies.

Does the participant sleep through the night?  Yes  No

If No, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any strong fears the participant may have: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any activities the participant especially dislikes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any activities the participant especially enjoys: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please use this space for any other information you feel would be helpful in providing the best experience for the participant. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PROGRAM INFORMATION

**Horseback Riding:** The program is held at Worthmore Farms, a riding center accredited by the Professional Association of Therapeutic Horsemanship (PATH). Instruction is provided under the direction of a PATH certified therapeutic riding instructor. All riders use a leader and side walkers.

**Swimming:** Swimming is a lifeguard supervised activity. All of our lifeguards, are trained on a yearly basis in Red Cross CPR and First Aid certified. Participants who are unable to swim wear life jackets and all campers must pass a swim test to be able to swim in the deep end.

**High Ropes:** A Challenge Course program accredited through ACA and the ACCT. Annually inspections are conducted on all equipment and the tower. Staff participate in yearly training. Participants are required to have trunk and head control to participate. Our high ropes course is based on a challenge by choice and is a Universal Climbing program for all abilities.

**Canoeing:** A lifeguard supervised activity, all of which are CPR and First Aid certified, as well as trained canoeing instructors. They are all also trained in Natural body of water rescues. Participants must have trunk and head control to participate.

**Transportation:** Camp Fairlee transports all participants by bus to canoeing and horseback riding. All buses are inspected on a routine bases.

**Hiking:** The trails at Camp Fairlee are flat and not strenuous: It is a 1 mile hike, and appropriate shoes are required. All trails are supervised.

**Hayrides and Campfires are weekly program activities all participants have the option of participating in.**

### Activity Restrictions (All activities are accessible for people with disabilities.)

A wide variety of programs are offered at Camp Fairlee, including those listed below. Please indicate which activities the participant should or should not engage in.

ACTIVITY	Ok To Participate	CANNOT Participate	ACTIVITY	Ok To Participate	CANNOT Participate
Horseback Riding			Transportation		
Swimming			Hayrides		
High Ropes (28' High)			Hiking		
Canoeing			Campfire		

Please list any other activities which you feel the participant be engaged in: