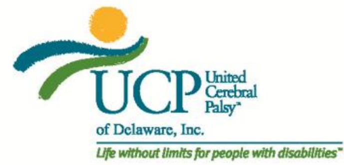


Camper Application

United Cerebral Palsy of DE, Inc.
700A River Road, Wilmington, DE 19809

CAMP MANITO

THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

The following information is required and should be completed by parent or guardian (Please Print)

Name: ____ Date: ____________

Address: _______________________________________

City: ________________State: _____ Zip: _________

Email: _______________________

Home Phone: _______________ Cell Phone:_____________

Female _______ Male: _________ Date of birth: ___________

Camper's School: ____________________ Phone: ____________

Father's Name:		Mother's Name:
Address (if different than camper's)		Address (if different than camper's)
Address:		Address:
City		City
State Zip		State Zip
Phone:		Phone:
Employer:		Employer:
Work number:		Work number:

In case of emergency, contact:1. _______________________ Phone: ________________

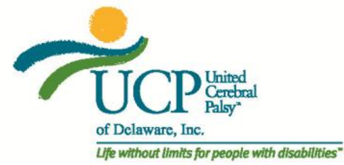
2. _______________________ Phone: ________________

Does your child: (Circle Yes or No)

Dress alone	Yes	No	Speak Well	Yes	No
Use a Wheelchair	Yes	No	Hear Well	Yes	No
Use a Walker	Yes	No	See Well	Yes	No
Require catheterization	Yes	No	Require tube feeding	Yes	No

My child may participate in the camp swimming program: Yes No
If yes, do you have any pool restrictions? ______________________________

***New early registration discounts are available. Please see page 6 for more information.**



Camper Application

Camper/Parent Authorization

IMPORTANT – Authorization must be completed for attendance.

The form is to be signed by the camper if the camper is age18 and over, or by the camper's parent/guardian if the camper is under age 18. The health history is correct so far as I know, and the person therein described has permission to engage in all prescribed camp activities except as noted in the application.

If the camper is age 18 and over, ______ (check) in the event of an emergency, I hereby give permission to the physician selected by the UCP Camp Director to order X-ray, routine tests, and treatment, and I hereby give permission to the physician selected by the Camp Director to secure proper treatment including hospitalization, medication, anesthesia, and/or surgery.

If the camper is under age 18,_____ (check) in the event of an emergency, I hereby give permission to the physician selected by the UCP Camp Director to order X-ray, routine tests, and treatment, for the health of my child, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure proper treatment for my son/daughter including hospitalization, medication, anesthesia, and/or surgery.

Parent/Guardian Signature: ________________________________ Date: _____________

Signature of Applicant: ___________________________________ Date: _____________

Insurance: ______________________________________ Other: _____________

Group Number: ____

Family Physician: _____________________________________ Phone: _______________

Address: ____

REFERENCE CHECK:
I hereby give permission to the staff of Camp Manito to contact my child's (adult's) school, teacher, and/or counselor for a reference, before being accepted to the Camp Program.

Camper's Signature (if over 18): ____
Parent or Guardian Signature (if camper is under 18 or dependent): ________________________
Date: ________________

Mail to: United Cerebral Palsy of Delaware, Inc.
700A River Road
Wilmington, DE 19809
Phone: (302) 764-2400
Fax: (302) 764-8713

Please return the following required documents:

1. **Camper Application**
2. **$30.00 Application Fee (excluding POC participants)**
3. **Medical Forms, as required**
4. **Proof of household income** **(2011 tax return, pay stubs, etc.)**

Complete applications (Items 1-4) must be received by June 7, 2012.

Camper Application

CAMP MANITO
MEDICAL HISTORY

To be completed by Family/Camper

Immunization history for ____(Camper's Name)
Does your child have a primary disability? If so, what is it? ______________________________
Please check below the following basic immunizations your child had:

☐	Diphtheria	☐	Measles	☐	H. Influenza
☐	Pertussis	☐	Mumps	☐	Tuberculin Test
☐	Tetanus	☐	Rubella	☐	Injectable Polio

Other (Please specify) ____
Has your child been diagnosed with a serious illness other than the child's disability?
Yes ____ No ____ If Yes, Explain. ____

Has your child in the last 12 months had any of the following: (please check)

☐	Frequent ear infections	☐	Seizures	☐	Asthma
☐	Diagnosis of heart defect or disease	☐	Diabetes	☐	Measles
☐	Bleeding/Clotting disorders	☐	Chicken Pox	☐	Pneumonia
☐	Urinary Tract Infection	☐	German Measles	☐	Hay Fever
☐	Other respiratory problems				

Has your child had an operation or serious injury in the last 12 months? ____________ Please explain____

Does your child have any allergic reactions to: (Please check)
Insect Stings ________ Penicillin __________ Food: ___________ Other :____________________

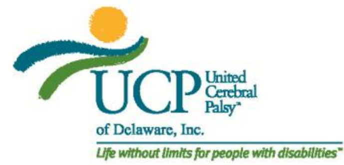
The date of child's last Tetanus shot. _______________

Does you child have a special diet or liquid intake requirements? _______ Fed by a tube? _____

Please list child's medication information:

Medication	Dosage	Time	Physician/Phone
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**

My child has permission to receive: Tylenol, Advil, Motrin, Benadryl. Please initial here: _____
Additional health or medical information/ details: _______________________________________
Other comments or instructions that might be helpful to the staff for easier handling of your child: ____
Any specific activities to be encouraged or restricted: _____________________________.
Parent or Guardian Signature: ____



CAMP MANITO

PHYSICAL

To be completed by Family Physician-
You may submit current school physical form instead of this Camp Manito physical form. Campers will not be admitted until we receive one of the two physical forms.

Camper's Name: ____
Age______ Height _____ Weight _____ Blood Pressure ______

Code: V= Satisfactory X= Not Satisfactory O= Not Examined
Eyes ______ Throat _____ Lungs ______ Extremities_______
Glasses _______ Heart ________ Abdomen ___ Posture (Spine) ______
Nose _____ Genitalia _______ Hernia _________ Skin __________
Allergies (Please Specify) ____
____
What medication is required? ____
Seizures (Please Specify) ____
____
What medication is required? ____
Other medications the camper takes regularly: _______________
____
General Appraisal ____
____
State the nature of disability giving diagnosis and degree of impairment or limitations.
____
____.

Can the camper participate in water activities? __________________________________
Recommendations and/or restrictions while at camp ______________________________
____
Other remarks ____
____
I have examined the person herein described and reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Date ____________ Telephone No. __________________
Signature: ____
Address: ____
Note to Physician! Very Important, if you fax your form please mail the original.

<u>Please return form via mail by June 7, 2012:</u>**
United Cerebral Palsy of DE, Inc.
700A River Road
Wilmington, DE 19809
Phone (302) 764-2400 ext. 10, Fax (302) 764-8713

Camper Application

CAMP ATTENDANCE SCHEDULE

Camper's Name:________________________
A minimum of one week is required for enrollment.

Week	**Please check the week(s) you plan to attend.**	**Camp Hours 7 am- 6 p.m.** **Please provide your anticipated drop-off and pick-up times.**
July 2- July 6		
July 9- July 13		
July 16- July 20		
July 23- July 27		
July 30- August 3		
August 6- August 10		

Please list the names and relationships of individuals who have permission to pick up your child(ren) from Camp Manito:

Name ________________________ Relationship ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

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

PHOTO CONSENT FORM FOR MINOR

I, as the parent or guardian of the minor identified below (the "Minor"), consent to the use by United Cerebral Palsy of Delaware, Inc. of the image or voice of the Minor, as recorded on a videographic, photographic, audiographic or other medium. This consent is granted whether the image or voice is used for fund raising, advertising, publicity or any other purpose.

I waive all claims for compensation or damages based upon the use of the Minor's image or voice by United Cerebral Palsy of Delaware, Inc or its agents, successors or assigns.

I waive any right to inspect or approve the finished product or the particular use made of the image or voice of the Minor. I understand that the Minor's image or voice may be modified or retouched, and I release United Cerebral Palsy of Delaware, Inc and its agents, successors and assigns from any liability by virtue of any blurring, distortion, alteration, misnaming, mislabeling or other modification that might occur.

I understand this consent is perpetual, that I may not revoke it, and that it is binding on the Minor and the Minor's heirs and assigns.

I represent and warrant that I am of legal age, that I am the parent or guardian of the Minor, and that I have the capacity and right to execute this consent. I further warrant that I have read this consent and understand its contents.

Printed Name of Minor: ____

Signature of Parent or Guardian:____

Printed Name of Parent or Guardian:____

Camper Application

CAMP MANITO
SUMMER CAMP FEES

Camper Name:____

Camp Fee
$160.00/ week (if application is received by 05/15/2012)
$ 175.00/week (if application is received after 05/15/2012)

Camp Hours
7:00 a.m. to 6:00 p.m.

The application fee of $30.00 is due with the application. POC participants do not need to pay this application fee. **Complete applications (Items 1-4) must be received by June 7, 2012.** All payments for Camp Manito must be in the form of check or money order. Please make payable to United Cerebral Palsy of DE. **NO CASH WILL BE ACCEPTED.** There will be a $35.00 charge for all returned checks.

Mail to: United Cerebral Palsy of Delaware, Inc.
700A River Road
Wilmington, DE 19809
Phone: (302) 764-2400
Fax: (302) 764-8713

Please return the following required documents:

1. **Camper Application**
2. **$30.00 Application Fee (excluding POC participants)**
3. **Medical Forms, as required**
4. **Proof of household income (2011 tax return, pay stubs, etc.)**

*All campers automatically have a UCP pool membership for the summer. Their parents can attend as a guest for a fee of $3 per visit. If you have any questions or concerns about the camp fees or pool membership, please call UCP at (302) 764-2400 ext. 10.

CAMPERSHIP INFORMATION

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 community organizations. The Camp Manito POC Site ID number is 1890271800. The number to call to see if you qualify for POC is (302) 255-9670. **We will help you through this process**. Please indicate your need for a campership by checking below.

________Yes _____ No

If applying for a campership, please submit your registration form with the application fee and verification of income. We will notify you concerning the status of your application.
Please indicate the reason for your need:

____

____

Please note that many community organizations require UCP to release to them the name, address, and in some cases the phone number of any child who receives a campership. The information is for the records of the community organization and will be kept confidential.

I give United Cerebral Palsy of Delaware, Inc. permission to release my name, address, and phone numbers to the organization that provides the campership for my child(ren).

Signature: ________________________________ **Date:** ________________________