UNITED CEREBRAL PALSY OF DELAWARE, INC.
CAMPER APPLICATION WINTER HOLIDAY RESPITE 2019

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY

Camper Name _____

Camper Information

Date of Application: _____

Full Name: _____ Date of Birth: _____/_____/_____

Nickname: _____ Age: _____ Gender (circle one) Female Male

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Please select how you plan to pay for camp:

☐ DFS ☐ DDDS ☐ Self-Pay ☐ Other _____

Camper's Health Information

Does the camper have a disability? ☐ Yes ☐ No If so, check all that apply

☐ Asperger's Syndrome
☐ Asthma
☐ Attention Deficit Disorder
☐ Attention Deficit Hyperactivity Disorder
☐ 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 ☐ Speech Delay
☐ Spina Bifida
☐ Spinal Cord Injury
Quadriplegic ☐ Paraplegic ☐ Other
☐ Social/Psychological
☐ Visual Impairment
☐ Partial ☐ Total
☐ Other Disability (s) _____
_____
_____

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Camper Name _____

Parent/Caregiver Information

Custodial Parent/Guardian: _____ Relation to Camper: _____
Primary Phone #: _____ Secondary Phone #: _____
E-Mail Address: _____

Address: _____
Street City State Zip

Custodial Parent/Guardian: _____ Relation to Camper: _____
Primary Phone #: _____ Secondary Phone #: _____
E-Mail Address: _____

Address: _____
Street City State Zip

Additional Contact Information

Emergency Contact #1:

_____
Name Relation to Camper Contact Phone # Authorized to Pick Up

Emergency Contact #2:

_____
Name Relation to Camper Contact Phone # Authorized to Pick Up

Drop-Off and Pick-Up Authorization

Drop off & Pick Up of the camper are the responsibility or the Parent/Guardian.

Is Camper utilizing transportation services Yes No If yes, the name of transportation service and contact number _____

I understand that only the above mentioned persons will be permitted to drop-off/pick-up my child, _____, from Camp Manito. 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.

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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:

_____

_____

Please list any fears the camper may have: _____

Please list any activities the camper dislikes: _____

Please use this space to tell us anything that we may have not asked or additional information to assist with your camper:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Medication and Medical

Please attach most recent physical and shot record. You do not need to provide these documents if your child attended camp the previous summer.

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 and initial the medications the camper is allowed to receive.

Tylenol Advil Motrin Cough Drops Benadryl Pepto-Bismol Calamine Lotion
Hydrocortisone 1% Cream Topical antibiotic cream

Permission for Prescription Medication Administration

1. Medication: _____ Dosage/Time: _____
   Purpose: _____
   Possible Side Effects: _____

2. Medication: _____ Dosage/Time: _____
   Purpose: _____
   Possible Side Effects: _____

3. Medication: _____ Dosage/Time: _____
   Purpose: _____
   Possible Side Effects: _____

4. Medication: _____ Dosage/Time: _____
   Purpose: _____
   Possible Side Effects: _____

PRESCRIPTION MEDICATION IS TO BE IN THE CONTAINER APPROPRIATELY LABELED BY THE PHARMACY OR PHYSICIAN. ALL MEDICATIONS ARE TO BE BROUGHT TO CAMP BY THE PARENT OR GUARDIAN, NOT SENT WITH THE CAMPER. WHEN CAMP ENDS FOR YOUR CAMPER, ALL MEDICATION IS TO BE TAKEN HOME BY PARENT OR GUARDIAN, NOT THE CAMPER. **CAMP MUST BE NOTIFIED IMMEDIATELY OF ALL MEDICATION CHANGES. *

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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

Bladder Control ☐No assistance Needed ☐Incontinent ☐ Needs Assistance

☐Catheter ☐Urinal ☐Disposable Undergarments ☐Other

Dressing ☐Assistance Needed ☐No Assistance Needed

Seizures ☐ Yes ☐ No Type _____ Frequency _____
Describe any warning signs before seizures: _____

Allergies ☐ None ☐ Hay Fever ☐ Poison Ivy ☐ Insect Stings ☐Penicillin
☐ Other _____

Feminine Needs Does the camper menstruate? ☐ Yes ☐ No
Special treatments for cramps? _____
List feminine products used and if she needs assistance: _____

Participation Please list any activities the camper may NOT participate in or attach precautions or special instructions for routine camp activities: _____

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Schedule and Fees

*Winter Respite will begin on the week of Christmas on Monday and end the following Tuesday.

$250 for the full week or $50/day	**Please check the day(s) you plan to attend.**	**Please provide your anticipated drop-off and pick-up times.**
Monday 8:30am-5:30pm (pack a lunch)		
Tuesday 8:30am – 1:30pm (pack a lunch)		
Thursday 8:30am – 5:30pm (pack a lunch)		
Friday 8:30am – 5:30pm We Treat For Lunch!		
Monday 8:30am – 5:30pm (pack a lunch)		
Tuesday 8:30am – 1:30pm (pack a lunch)		

Payment is due at time of drop off on the first day of attendance for the week. If only attending certain days, then payment is due the morning of each day. Payment can be made via check, money order, or credit card. A $20 daily fee will be charged for each day your payment is late.

"Late Pick-up Fees (after hours): Parents picking up children after the closing time will be charged a late fee. If the camper is picked up between 5:31pm and 5:44pm, you will be charged $2. Starting at 5:45pm, it is an additional $1 per minute. This is per child with no cap. Fees are due upon pick up.

_____

Acknowledgement Signature and Date

Waivers & Releases

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(1) **Approval, Waiver, and Activity Consent:** This application has my approval. While UCP of DE's, Camp Manito will take every precaution, it is agreed that UCP of DE's, Camp Manito 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 Manito 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 Manito, 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 Manito. The undersigned hereby agrees also to hold UCP of DE's, Camp Manito 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 Manito'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: _____

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