

Checklist for Camper Application

Please use this checklist to complete your application. Incomplete applications cannot be reviewed or accepted. Since we have limited space, this could affect your acceptance into camp.

FOR ALL APPLICANTS:

Personal Data Form

Page AP-2

- General Information
- Applicant's Residence
- AHRC Involvement and Service Coordinator sections

Page AP-3

- Emergency Contact #1, #2 and #3 completed
- Insurance information completed

Daily Living Skills – Pages AP-4 and AP-5

- All boxes on both pages reviewed and checked

General Medical Information – Pages AP-6 and AP-7

- Complete boxes #1 – 26. Add comments for any questions that you answer “yes.”

A Physical from your primary physician does not have to accompany this application but is required prior to final acceptance for camp

Attachments

Insurance information:

- Copy of Medicare card and Medicare Part D card if this applicant has Medicare
- Copy of Medicaid card, if this applicant has Medicaid
- Copy of private insurance card, if this applicant has private insurance
- 3 current photos
- A non-refundable \$50 application processing fee. Checks or money orders should be made payable to 'AHRC Camping Department'.

Other Medical information:

- Dining Facts Sheet
- Medication Record
- Immunization Record

ADDITIONAL MEDICAL INFORMATION NEEDED:

If your camper is applying for the first time **OR** if you have not sent a current psychological to AHRC since **07/01/09**, please attach:

- a copy of current psychological exam and psycho-social exam, **dated within the last 3 years (after 01/01/07)**

IF APPLICABLE TO YOUR CAMPER PLEASE COMPLETE AND INCLUDE:

- Transfer/Position/Mobility Fact Sheet
- Seizure Questionnaire

OPTIONAL ATTACHMENTS

- Financial aid form, with requested financial documents.

Name of person completing this checklist and application:

Email address:

Phone number where we can usually reach you during daytime hours:

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Please attach and email completed applications and attachments to:

campregistration@ahrcnyc.org

**Camp Anne
and
Harriman Lodge**

Personal Data Form

For Office Use Only	
Date Application Rec'd _____	
CA <input type="checkbox"/>	HL <input type="checkbox"/>
P/H Accommodation <input type="checkbox"/> yes <input type="checkbox"/> no	
Initial Here _____	

Camp History	
Returning Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Applicant Attended Another Camp?
Camp Anne <input type="checkbox"/> Harriman Lodge <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Last Year of Attendance? _____	Name? _____

Please do not make your vacation plans until you receive confirmation of the camp session

Preferred Session? (Check one or more) 1 2 3 4 5

General Information
Applicant's Name _____ Phone # (____) _____
Email address: _____
<input type="checkbox"/> Check here if you want to receive information from other AHRC Departments.
Applicant's Street Address _____ (Apt #) _____
_____ (City) _____ (State) _____ (Zip Code)
Date of Birth ____/____/____ Age _____ Sex _____
Applicant's Social Security # _____
Applicant's Primary Disability is? _____
Does the Applicant use a Wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No
Language(s) Spoken by Applicant _____

**IMPORTANT
Please
Include
Three
Passport
Photos**



(This is extremely important for the safety of the applicant.)

Applicant's Residence (check only one box)
<input type="checkbox"/> Home (natural family) <input type="checkbox"/> With Relatives
Name of parent/relative _____
Language spoken _____
<input type="checkbox"/> Group Home - IRA <input type="checkbox"/> Family Care
<input type="checkbox"/> Group Home - ICF <input type="checkbox"/> Foster Care
<input type="checkbox"/> Group Home Community Residence <input type="checkbox"/> State-operated IRA/ICF
<input type="checkbox"/> Other _____
Name of Group Home/ Agency _____
Address _____
Name of Manager/ Guardian _____
Phone # (____) _____

Day Program / AHRC Involvement
Which Day Program or School Does Applicant Attend? _____ School: 10 Month Program
Contact Name _____ Phone # (____) _____ 12 Month Program
Is Applicant Involved with any AHRC Programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Which Ones? _____

Service Coordination
Does applicant have a Social Worker or Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No
MSC Medicaid Service Coordinator? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____ Agency: _____
Address _____
Phone # (____) _____ Email: _____

Emergency Contact Persons (Must include primary caregiver)

1st Parent/Guardian Contact _____ Relationship _____

Is this Person the Legal Guardian? Yes No (If NO please name Legal Guardian below)

Phone #1 Home (_____) _____

Phone #2 Work (_____) _____

Phone #3 Cell (_____) _____

2nd Emergency Contact (OTHER THAN PRIMARY CAREGIVER) _____

Relationship _____

Phone #1 Home (_____) _____

Phone #2 Cell (_____) _____

3rd Emergency Contact (OTHER THAN PRIMARY CAREGIVER) _____

Relationship _____

Phone #1 Home (_____) _____

Phone #2 Cell (_____) _____

LEGAL GUARDIAN:

NAME: _____

Phone # (_____) _____

Insurance Information

APPLICANT NAME: _____

CHECK ALL THAT APPLY: Medicaid # Medicare # Medicare Part D Private Ins.

INCLUDE COPIES OF MEDICAID CARD, MEDICARE CARD, MEDICARE PART D PLAN CARD, PRIVATE INSURANCE CARD(S)

OR PRIVATE INSURANCE

Name of Policy Holder _____

Social Security # of Policy Holder _____

Relationship to Applicant _____

Policy Holder's Employer _____

Employer's Address _____
(City) (State) (Zip Code)

Insurance Name _____

Insurance Address _____
(City) (State) (Zip Code)

Daily Living Skills - 2010

Please complete both sides of the following questionnaire.
Your answers will assist us in providing a safe and enjoyable vacation experience.

Applicant's Name _____

Communications

- Uses speech, full and/or short sentences
- Clear, single words
- Difficult to understand
- Attempts words, unclear
- Non Verbal

If non-verbal:

- Uses sign language
- Uses gestures
- Has communication board, other device or pictures
- Does not outwardly appear to communicate

Activity Level

- Initiates own activities, shares interests with others
- Very active, at times impulsive
- Requires occasional encouragement to complete activity

- Does not initiate activities however participates with continual encouragement and/or supervision
- Does not willingly participate in most activities

Comprehension

- Understands most conversations
- Understands most directions

- Limited understanding of conversations/ directions
- Does not outwardly respond

Interests

- | | | |
|--------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Dance | <input type="checkbox"/> Acting | <input type="checkbox"/> Music |
| <input type="checkbox"/> Drawing | <input type="checkbox"/> Cooking | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Basketball | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Pool | <input type="checkbox"/> Boating | <input type="checkbox"/> Horses |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Animal Care | <input type="checkbox"/> Running |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Singing | Other: _____ |

Favorite leisure activity is _____

While on vacation applicant is most looking forward to: _____

Does applicant have any known fears? If so, please explain

Socialization

- Enjoys activities with others
- Accepts limited contact with others
- Prefers solo activities

Applicant is currently working toward goals outlined in a behavioral plan.

Yes no

NOTE: To ensure quick response regarding your application, please provide a copy of the behavior plan when you return this application.

Engages in behavior that can be harmful to self or others

Rarely Often Never

Please explain : _____

Mobility

- Walks independently
- Requires occasional physical assistance walking over uneven ground, up stairs and over difficult terrain
- Utilizes cane or walker (please circle which)
- Requires direct physical assistance of one person while walking at all times

For wheelchair users: **(More complete information will be required with acceptance package)**

- Wheelchair for long distances only
- Wheelchair at all times (Manual Electric)

Bathing and Showering

- Independent, no assistance
- Requires verbal prompting, reminders

- Hand over hand physical assistance required to complete task
- Total assistance required with all bathing tasks

Applicant Name: _____

Dining Room Skills

- Uses fork, knife and spoon
- Uses fork and spoon only
- Requires adaptive spoon or fork
- Requires plate guard
- Requires assistance to drink hot and cold liquids from cup/ glass
- Drinks liquids from adaptive cup with no assistance
- No known risks for choking
- Needs constant supervision while eating

- Wears dentures
- Eats rapidly
- Difficulty with chewing
- May "stuff" food

Generally appetite is:
 Fair Average Excessive
Favorite foods include: _____

Toileting Skills

- Uses toilet independently
 - Requires supervision on toilet
- Requires incontinence pads
 Day Night Both
- Uses words or other method to indicate need. Explain:

- (Female only)
- Independent with menstrual care
 - Some assistance required with menstrual care
 - Total assistance needed with menstrual care

Dressing

- Independent, no assistance
- Requires verbal prompting, assist with appropriate clothing selection

- Physical support needed with buttons, zippers, tying shoes
- Total assistance required with all tasks

Sleeping Habits and Routines

- Usually goes to sleep at _____ PM
Usually wakes at _____ AM
- Has difficulty sleeping at night
 Rarely Sometimes Always
- Gets out of bed during the night
 Rarely Sometimes Always
- Requires repositioning throughout night
- Explain: _____

- Requires bed rails at night (*Script required for bed rails*)
 - Wets the bed at night
- Requires special equipment to maintain position and prevent skin breakdown
 Straps Egg Crate Pillows
 Wedges Cushions Bolsters
- If individual has difficulty sleeping, the usual intervention is to:

Medications /Medical Care

Takes medication Yes No (If yes complete the medication list attached)

Is the individual cooperative for health exams? Yes No
Explain:

Person Completing Form: _____ **Date:** _____

Camper/Guest Name: _____

General Medical Information – 2010

1.	Is Primary Diagnosis Mental Retardation	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Profound <input type="checkbox"/> Severe	<input type="checkbox"/> Moderate <input type="checkbox"/> Mild	(Note: Selected category must match psychological / psychosocial report)	
2.	Secondary Diagnosis	Please List: _____				
3.	Allergies to Medications	<input type="checkbox"/> yes <input type="checkbox"/> no	Please List: _____			
4.	Allergies to Food or Environment	<input type="checkbox"/> yes <input type="checkbox"/> no	Please List: _____			
5.	Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Nebulizer treatment Inhalers	<input type="checkbox"/> Daily <input type="checkbox"/> Daily	<input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes	<input type="checkbox"/> Never <input type="checkbox"/> Never
6.	Respiratory (breathing) Difficulties	<input type="checkbox"/> yes <input type="checkbox"/> no	Requires Oxygen treatment: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Never Requires CPAP, BiPap or other treatment during nighttime: <input type="checkbox"/> Yes <input type="checkbox"/> No			
7.	Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	Medications	<input type="checkbox"/> yes <input type="checkbox"/> no		
8.	Constipation	<input type="checkbox"/> yes <input type="checkbox"/> no	Frequency of bowel movement _____ Requires suppository <input type="checkbox"/> yes <input type="checkbox"/> no How often? _____ Enema <input type="checkbox"/> yes <input type="checkbox"/> no How often? _____			
9.	Blood/Metabolism Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	If 'Yes' provide diagnosis: _____ Requires laboratory work during stay at camp? <input type="checkbox"/> yes <input type="checkbox"/> no			
10.	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Oral medications <input type="checkbox"/> yes <input type="checkbox"/> no Insulin injections <input type="checkbox"/> yes <input type="checkbox"/> no Requires blood glucose monitoring : <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how often, what times of day: _____ _____			
11.	Bowel Incontinency Urine Incontinency	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> catheter	Requires incontinence protection: <input type="checkbox"/> At all times <input type="checkbox"/> At night only <input type="checkbox"/> Sometimes <input type="checkbox"/> Transport			
12.	Epilepsy / Seizure activity	<input type="checkbox"/> yes <input type="checkbox"/> no	If YES, complete seizure questionnaire attached.			
13.	Frequent Ear Infections	<input type="checkbox"/> yes <input type="checkbox"/> no	Wears ear plugs for	<input type="checkbox"/> Shower <input type="checkbox"/> Swimming <input type="checkbox"/> Never		
14.	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Requires blood pressure monitoring: <input type="checkbox"/> More than once a day <input type="checkbox"/> Daily <input type="checkbox"/> Twice a week <input type="checkbox"/> Once a week			
15.	Hepatitis (infectious)	<input type="checkbox"/> yes <input type="checkbox"/> no	Type: _____			
16.	Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	If 'Yes' provide diagnosis: _____			

17.	Hearing difficulty	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Total hearing loss <input type="checkbox"/> Right ear only	<input type="checkbox"/> Severe loss <input type="checkbox"/> Left ear only	<input type="checkbox"/> Mild loss <input type="checkbox"/> Both ears	Wears hearing aid <input type="checkbox"/> All the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	
18.	Psychiatric Diagnoses	<input type="checkbox"/> yes	<input type="checkbox"/> no	Diagnosis: _____				Behavior plan <input type="checkbox"/> yes <input type="checkbox"/> no
Reminder: Please send copy of plan with application								
19.	Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Has received treatment in the past? <input type="checkbox"/> yes <input type="checkbox"/> no				Start date of treatment: _____
	Was PPD result positive	<input type="checkbox"/> yes	<input type="checkbox"/> no					
20.	Skin Condition	<input type="checkbox"/> yes	<input type="checkbox"/> no	Open areas present		<input type="checkbox"/> yes	<input type="checkbox"/> no	
				History of open areas:		<input type="checkbox"/> yes	<input type="checkbox"/> no	
21.	Stomach Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Describe: _____				
22.	Swallowing Difficulty Chewing Difficulty Special Diet	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes to any question, complete the Dining Facts Sheet attached.				
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
23.	Vision	<input type="checkbox"/> Normal	<input type="checkbox"/> Partially blind	<input type="checkbox"/> Legally Blind				
		<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left eye	<input type="checkbox"/> Both eyes				
		Wears corrective lenses:		<input type="checkbox"/> All the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never		
24.	Osteoporosis (bone disorder)	<input type="checkbox"/> yes	<input type="checkbox"/> no	Explain: _____				
25.	Period Period, Irregular, painful Menopausal	<input type="checkbox"/> yes	<input type="checkbox"/> no	Menses occur every _____ days.				
		<input type="checkbox"/> yes	<input type="checkbox"/> no	Date of last menses cycle: _____				
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
26.	Any recent injury Illness Hospitalizations Emergency Room Visit History of Falls Takes medication	<input type="checkbox"/> yes	<input type="checkbox"/> no	Please give details for any 'Yes' answer				
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
		<input type="checkbox"/> yes	<input type="checkbox"/> no					
		<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, to medications, complete the medication list attached				
		<input type="checkbox"/> yes	<input type="checkbox"/> no					

Complete Both Sides **SIGN and DATE**

Person Completing Form: _____

Camper/Guest Name: _____

Date: _____