



# ***CAMP DISCOVERY***

## ***Summer Camp***

*A social skills day camp  
for children with special needs*

Serving children ages 3-14 years old  
Session 1: June 18<sup>th</sup>-29<sup>th</sup>  
Session 2: August 20<sup>th</sup>- August 31<sup>st</sup>

Welcome to Camp Discovery, a camp program dedicated to serving children with special needs! Camp Discovery is conveniently located at 330 South Ave, Fanwood, NJ 07023. The overall goal of Camp Discovery is to teach and implement age appropriate social skills. This will be completed through a complete curriculum which has been created by a Board Certified Behavior Analyst. Each activity and lesson that the children are taught will be in an ABA format and conducted by highly trained ABA therapists.

**The final summer camp registration deadlines are June 1<sup>st</sup> for session 1 and July 21<sup>st</sup> for session 2.** In order to guarantee a spot in the program, we will need to receive your registration form and payment by this date. If you are unable to pay in full and would like to work out a payment plan please indicate this on your registration packet. Packets can be emailed back to: Adrienne Norman at [anorman@firstchildrenservices.com](mailto:anorman@firstchildrenservices.com).

Packets can also be mailed to: Adrienne Norman  
First Children Services  
330 South Avenue  
Fanwood NJ 07023

We offer an early registration discount of 10% off the full or half day rate if you register by April 15<sup>th</sup>. We also offer a sibling discount of 10% off the second child (full or half day rate). Discounts cannot be combined.



## Emergency Contact/Parental Consent Form

Camper's Name: _____	Date of Birth: _____
Primary Telephone Number: _____	Primary Email Address: _____
Address: _____ City: _____ State: ____ Zip Code: _____	
Allergies: _____	

**Mother's Name/Legal Guardian:** \_\_\_\_\_

Home address: _____	Telephone Number: _____
Employer Name and Address: _____	
Employer Telephone Number: _____	Email Address: _____

**Father's Name/Legal Guardian:** \_\_\_\_\_

Home address: _____	Telephone Number: _____
Employer Name and Address: _____	
Employer Telephone Number: _____	Email Address: _____

**Emergency Contact Person(s)**

Name and Relationship	Telephone Number
1) _____	1) _____
2) _____	2) _____

**Person(s) to whom Child May be Released:**

Name and Address (Relationship)	Telephone Number
1) _____	1) _____
2) _____	2) _____

**PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT**

Obtaining Emergency Medical Care	Admin. Of Minor First-Aid Procedures
Emergency Restraints for Safety	Outdoor Activities

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



## Child Background and History

### SCHOOL INFORMATION

School District: _____	Type of Classroom: _____
Behavior Plan? ___y / n_____	*If yes please provide a copy of the plan*
Services Received (inschool) _____	

### COMMUNICATION

Please indicate how your child communicates by checking all that apply:

\_\_\_ Verbal    \_\_\_ Sign    \_\_\_ Device    \_\_\_ other (please specify) \_\_\_\_\_

### BEHAVIORS

Please check all behaviors below that your child exhibits. Where applicable indicate frequency.

Aggression _____	Frequency _____
Self Injury _____	Frequency _____
Elopement _____	Frequency _____
PICA _____	Frequency _____
Tantrum _____	Frequency _____
Other(specify) _____	Frequency _____

Is your child toilet trained? \_\_\_y / n \_\_\_\_\_



## Additional Information

### LIKES AND DISLIKES

Please list and describe your child's likes and motivators:

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Please list and describe your child's dislikes and triggers:

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### ADDITIONAL INFORMATION

Please provide a brief narrative of your child's strengths:

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Please provide a brief narrative of your child's areas of need:

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Please provide any other important information you would like to share about your child:

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## Rates and Registration

Full Day (9am-3pm) \$600/week Before Care (8am-9am) \$15/hour  
 Half Day (9am-12pm or 12pm-3pm) \$300/week After Care (3pm-6pm) \$15/hour

### Registration (Please check all that apply)

Week Of:	Full Day Week @ \$600	Half Day Week @ \$300 <small>Circle AM or PM</small>	AM Care \$15/hour	PM Care \$15/hour	Weekly Total
6/18/18		AM PM			
6/25/18		AM PM			
8/20/18		AM PM			
8/27/18		AM PM			
<b>Early registration discount or sibling discount (10% full or half day rate) *</b> <small>*Only one discount may be applied per camper</small>					-
Total=					

(Approved method of payments include insurance reimbursement, cash, check & credit card)

If a camper is picked up late, parents will incur a late fee of \$10/15 min that the pickup is late. Please make every effort to contact us if you will be late picking up your camper.



## Payment Form

I am paying by check\* (Please make checks out to First Children Services)

\*There will be a \$35 fee for returned checks

I am paying by cash (Must be received prior to camp start date)

Other funding source \_\_\_\_\_

### Credit Card Payments

Visa

MasterCard

American Express

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Amount \$ \_\_\_\_\_

CCV code (security code-3 digit number on back for Visa/MC, 4 digits on front of AMEX): \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Camp Discovery Medication Policy and Guidelines

First Children Services, in keeping with N.J. State regulations, has established the following policies and procedures regarding the administration of medication during the camp day. Medications shall include all over the counter (non-prescription) medications as well as medications available only by prescription. All medications will be kept in a locked cabinet. Any medication requiring refrigeration will be kept in a separate locked box in the refrigerator. No medications are to be kept or administered by campers.

Each medication must be properly labeled. **Pharmacy labels are required for all prescriptions.** You can request your pharmacist to place each prescription medication into two (2) labeled containers: one for the health director and one for home use. Over the counter medication must be sent in the original container with the camper's name written on it. Medications are to be turned into the camp director or health director along with the Medication Permission Authorization forms. **The forms must be completed and must include signatures by both parent/guardian and physician as well as a physician's stamp.** Medications will not be administered without a completed form.

**For campers sending Epinephrine Auto Injector to camp:** If needed, the health director will administer the epinephrine auto injector and call 911. If, for any reason the health director is not present to administer the epinephrine auto injector, a trained delegate may administer it. If, for any reason, the delegate is unable to administer the epinephrine auto injector, 911 will be called to support the child. Antihistamines cannot be given by the delegate. If the health director is not available, the delegate will administer epinephrine auto injector only and call 911.

All medications along with completed Medication Permission Authorization forms must be handed to our health director prior to the camp start date. Please make sure you have the medication permission form completed and signed by your physician. Medication will only be dispensed to the camper for whom it has been prescribed. All staff members will be informed of any medication needs of campers they will be responsible for. Any adverse reactions to medications will be reported to the parents and guardians and prescribing physician.

**Medications and forms are to be handed in together. Any unused medication will be returned to the parent or guardian on the last day of camp. If we are unable to return any medication, it will be destroyed.**

## Camp Discovery Medication Permission Authorization Form

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_

\*Medication: \_\_\_\_\_ Dosage: (indicate in mg) \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Time to be given: \_\_\_\_\_

Medication cautionary information \_\_\_\_\_

\*Medication: \_\_\_\_\_ Dosage: (indicate in mg) \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Time to be given: \_\_\_\_\_

Medication cautionary information \_\_\_\_\_

\*Medication: \_\_\_\_\_ Dosage: (indicate in mg) \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Time to be given: \_\_\_\_\_

Medication cautionary information \_\_\_\_\_

### I give the health director permission to give:

Acetaminophen    \_\_\_ Yes \_\_\_ No    Dosage \_\_\_\_\_

Ibuprofen        \_\_\_ Yes \_\_\_ No    Dosage \_\_\_\_\_

Benadryl         \_\_\_ Yes \_\_\_ No    Dosage \_\_\_\_\_

Camp Discovery does not provide any medication. If you would like us to be able to administer over-the-counter medication, you must provide the medication to us in the original bottle with expiration date on it. Each bottle must be labeled with the child's full name.

**For campers bringing epinephrine auto injectors:** In signing this statement, I understand that if my child needs his/her epinephrine auto injector, and the health director is not present, a trained delegate may administer the epinephrine auto injector.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Below must be completed by the parent/guardian AND physician for all medications you wish to have your child take during camp.***

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office phone #: \_\_\_\_\_

Physician Comments: \_\_\_\_\_





## Camper Health History Form

Camper name: \_\_\_\_\_

Please list any known physical conditions:

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Please list any known mental conditions:

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Please list any known allergies:

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Is there anything else we should know about the camper's health? \_\_\_\_\_

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\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Immunization paperwork attached: Yes

No