SUMMER TEEN ADVENTURE CAMP (STAC)

A week by week summer program for individuals with special needs ages 13-17

Application Period: Thursday, February 1st, 2018 through Friday, April 15th, 2018

Space is limited

Application Process:

1. Return completed Application *(including signed release and medication sheets found at the end of this application),* Current Photo, Current IEP/BIP/FIE, as well as any other supporting documentation to include PDP, Medical Records, etc. to:

Jennifer Tarr
Summer Teen Adventure Camp
c/o The Arc of San Antonio
13430 West Avenue
San Antonio TX 78216

*Please Note: Incomplete Applications will ***not*** be considered.

2. Once application is submitted, you will be contacted to schedule a **mandatory face to face application review** to determine acceptance into the program.
3. **Once notified of acceptance**, non-refundable deposit of $25 per program week will be due.
4. **Complete payment is due in full by Friday, May 18th, 2018.**

Camps will be held during the following weeks:

- **Just Sports! (6/11/18-6/15/18)**
- **Animal Adventure Camp (6/18/18-6/22/18)**
- **Rock N Roll SA (6/25/18-6/29/18)** (this week is specifically designed for individuals who need more physical assistance)
- **Ocean Life Camp (7/9/18-7/13/18)**
- **Lights, Camera, Action! (7/16/18-7/20/18)**

***At this time due to the safety of the participants, we are unable to accommodate the following:

- Uncontrolled or frequent seizure activity
- Tracheotomies
- Individuals requiring changing tables
- Individuals requiring one-on-one supervision
- Behaviors including (but not limited to) aggression, elopement, etc.

* For a full list of behavioral concerns, please see page

Applicant Information

First Name_____ Last Name_____

Preferred Name_____

Address_____

City_____ State _____ Zip _____Phone _____

Cell Phone_____ Email_____ Date of Birth____/____/_____

Primary Diagnosis/Disability_____

Gender: ☐Male ☐Female Height_____ Weight_____ Adult Shirt Size:☐XS ☐S ☐M ☐L ☐XL ☐XXL

Parent/Guardian Information

Name_____ Relation to Applicant_____

Address_____ City_____ State_____

Zip_____ Day Phone_____ Evening Phone _____

Cell Phone_____ Email _____

Emergency Contact Person #1 (This person must be available during session)

Parent/Guardian? □ yes □ no (if no please complete the information below)

Name_____ Relation to Student_____

Address_____ City_____ State_____

Zip_____ Day Phone_____ Evening Phone _____

Cell Phone_____ Email _____

Emergency Contact Person #2 (This person must be available during session)

(Please provide secondary emergency contact)

Name_____ Relation to Student_____

Address_____ City_____ State _____

Zip_____ Day Phone_____ Evening Phone _____

Cell Phone_____ Email _____

Name of Applicant_____

Applicant Information (continued)

Please indicate the most recent educational program in which the applicant has participated. Elaborate as needed to illustrate achievements and/or to identify areas for improvement. Continue on additional sheets if necessary. Release of Information to speak with current school is at the end of this application.

Name of school or program_____ Dates/years attended _____

Briefly describe the applicant's overall experience with this program (strengths, areas for improvement, etc.)

_____

_____

_____

_____

Hobbies: _____

_____

_____

Favorite sports and athletics: _____

_____

Level of participation in the sports listed above: _____

Favorite forms of entertainment: _____

_____

_____

_____

Assistance/Guidance needed for any recreational activities: _____

_____

_____

_____

Name of Applicant_____

Diabetic

☐ Yes (see eating/diet section) ☐ Insulin Dependent

☐ No

Eating/Diet

Feeding Assistance: ☐Yes ☐No

Food must be: ☐cut ☐ chopped ☐mashed ☐pureed

☐ Diabetic Diet

☐ Special Diet_____

☐ G – tube

☐ Retainer ☐ Braces ☐ Dentures

Allergies

☐ None ☐ Yes (list below) ☐ Epi-Pen

Food:_____

Medicine:_____

Other:_____

_____

Seizures

☐ None ☐ Regularly ☐ one or two as child

☐ currently controlled with medication

Type(s): _____

Date of Last Seizure: _____

Usual Frequency:_____

Usual duration of seizures: _____ minutes

Triggered by: _____

Diagnosis: Please list all (ex. seizures, autism, asthma, diabetes, ID, anxiety, depression, etc.)

1._____

2._____

3._____

4._____

5._____

Medications

☐ No Meds ☐ PRN meds only

Medication	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

attach additional sheet if needed

PRN List and Med Order at end of packet to be signed by physician

☐ Student can administer medication independently

☐ Student needs reminder, but can administer independently

☐ Student needs help administering medication

Medication Policy

All prescription medications that the student will bring should be recorded on this form regardless of whether or not he/she is administering independently. All prescription medication must be in the original prescription container and should contain only the amount of medication needed for the duration of program. Exceptions to this policy will be considered on an individual basis.

Name of Applicant_____

Ambulation

☐ Walks unassisted

Walks using: ☐ walker ☐ crutches ☐ braces ☐ car

Wheelchair: ☐ manual ☐ electric (bring charger)

Participant is able to: ☐sit unassisted

☐transfer with assistance ☐bear weight/pivot

Communication

☐ No limitations

☐ Limited but can communicate daily needs

☐ Non-verbal

☐ Sign Language

Vision

☐ Normal ☐ Glasses/Contacts ☐ Blind

Hearing

☐ Normal ☐ Hard of Hearing ☐ Aids ☐ Deaf

Sleep

☐ No Problems Usual bed time:_____

☐ Walks in sleep Awakes at:_____

Personal Hygiene: Brush Teeth, Bathe, Toilet, Dressing, etc.

☐ Independent

☐ Needs assistance with: _____

_____

☐ Needs total assistance in all areas

Additional Instructions

_____

_____

_____

Behavioral Issues (i.e. aggression, elopement, etc.)

□ No □ Yes If yes, please explain in detail. Please attach behavior plan and other supporting information.

_____

_____

_____

_____

_____

Activity Restrictions

□ Yes □ No

Explain: _____

_____

Heat Tolerance

□ Good □ Fair □ Poor

□ Dehydrates Easily

Swimming

Does the applicant know how to swim? □Yes □ No

Ear plugs when swimming? □ Yes □ No

Does applicant ever wander or stray when in a community setting?

□ Yes □ No □ Occasionally

Additional Equipment

□ None □ CPAP/BiPaP □G-tube □Feeding Pump

□ Baclofen Pump □ Other_____

* Please note that we **may not** be able to accommodate G-tubes, feeding pumps, and Baclofen pumps. Please contact us for more information.

Please Note:

1. *STAC* is for individuals who are willing and able to participate in group activities.
2. *STAC* is not appropriate for individuals requiring one-on-one supervision.
3. STAC participants must be able to tolerate being outdoors for extended periods of time.
4. Behaviors that disrupt the normal functioning of *STAC* may result in the individual being dismissed and no refund of fees will be granted. Such behaviors include, but are not limited to:

- Wandering, running away, elopement
- Foul language, cursing
- Fighting
- Tantrums
- Willful destruction of property
- Sexual acting out
- Self-injurious behavior
- Extreme hypochondria
- Throwing objects
- Emotional outbursts

Name of Applicant_____

Insurance Information:

Insurance Carrier:_____ Group Number:_____

Member/Insured Name:_____

Physician:_____ Phone:_____

*If applicant has Down Syndrome, stable for atlanto-axial subluxation: □ Yes □ No

Date of most recent cervical x-ray: _____

Immunization or Date of Illness (or attach immunization records)

Polio _____, type_____

Measles_____

HIB_____

Diphtheria/Pertussis/Tetanus_____

Rubella _____

Other:_____

Medication Policy:

All prescription medications that the student will bring must be recorded on this application regardless of whether or not he/she is administering independently. All prescription medication must be in the original prescription container and should contain only the amount of medication needed for the duration of the STAC week. All attendees must have a physician's order for prescription medication. The physician's order as well as the PRN Med List to be signed by the physician can be found at the end of this packet.

Name of Applicant_____

Permission/Release Form

Please initial each statement

Medical

_____ **Permission to Obtain Medical Treatment**: I give my consent by signature below for medical treatment to be obtained for my child participating in the STAC program in the event I (or my designee) am unable to.

_____ **Permission to share Medical Information:** I authorize the STAC program and The Arc of San Antonio staff and volunteers to share, without restriction, my child's health information and medical records with any person relating to medical services or treatment

_____ **Prescription Medication Policy:** I affirm that I have read the policy concerning prescription medication.

_____**Agreement to Pay for Medical Treatment:** I understand that in the event of a medical emergency affecting child, EMS may be called and my child ward may undergo hospitalization and/or treatment. I agree to assume all costs associated with such summoning of emergency medical care, hospitalization, and treatment, and I hold STAC program staff, The Arc of San Antonio Staff, and volunteers harmless for any liability, medical or financial arising from such.

Transportation for Activities and Emergency Transportation

_____ **Consent/Permission to participate in off-site activities** that are specific to the STAC program.

_____ **Consent/Permission for STAC Program and The Arc of San Antonio staff to transport** the participant to off campus activities specific to the program.

_____ **Consent/Permission for STAC Program and The Arc of San Antonio staff to transport** the participant in the event of a medical, facility, environmental, or natural disaster.

_____ **Consent/Permission for STAC Program and The Arc of San Antonio staff to transport the participant in their personal vehicle** for off campus activities specific to the STAC program or in the event of a medical, facility, environmental, or natural disaster.

Name of Applicant_____

Permission/Release Form (continued)

Please initial each statement

Photographs/Videos

_____ **Consent/Permission for photos or video** to be taken during the STAC program for the purpose of compiling a Memory Book to share among the staff and participants.

_____ **Consent/Permission for photos or video** to be used by **STAC Program and The Arc of San Antonio** to portray or promote The Arc of San Antonio on all social media platforms.

_____ **Consent/Permission** for the student's first name to be published in conjunction with photographs or video. (Last names **will not** be published.)

Release of Confidential Information

_____ **Consent/Permission for the participant's confidential information** to only be shared with **STAC Program and The Arc of San Antonio staff** for programming purposes only.

I,_____ , guarantee that the information on this application is accurate and hereby release and forever discharge *The Arc of San Antonio*, its members, employees, and volunteers from any liability, suit, claim, or demand, whether for personal injury to myself or members of my family including minor children, or for property damage which result from any participation in the program.

Parent/Legal Guardian Print_____

Parent/Legal Guardian Signature_____ Date_____

Name of Applicant_____

STAC Behavior Checklist

Each applicant will be evaluated on an individual basis. A face to face application review is mandatory prior to application acceptance. Please note that some behaviors listed below that occur with enough frequency to disrupt the normal functioning of the program may result in dismissal and no refund of fees will be granted.

	Yes	No
1. Wanders off or runs away	____	____
2. Needs help to feed self	____	____
3. Throws Objects	____	____
4. Emotional Outbursts	____	____
5. Tantrums	____	____
6. Physically fights with others	____	____
7. Injures self	____	____
8. Willfully destroys property	____	____
9. Bites, Scratches, kicks	____	____
10. Foul language/cursing	____	____
11. Continually complains of unfounded illness	____	____
12. Hallucinates to the point of dysfunction	____	____
13. Needs assistance for toileting needs	____	____
14. Frequent insubordination	____	____
16. Difficulty working with peers	____	____
17. Needs one-on-one supervision	____	____
18. Demonstrates sexual advances toward others	____	____
19. Taunts or bullies others	____	____

Explanation for any of the above that were answered “yes”: _____

_____

_____

_____

I understand that applicants and program participants unable to meet behavior criteria will be dismissed from the program and that program fees will not be refunded.

Parent/Guardian_____ Date _____

Name of Applicant_____

Attendance and Payment Information

Tuition: $250 per week Total fee must be paid no later than May 18th, 2018.
A limited number of reduced rate slots are available. Contact The Arc of San Antonio's finance office for more information. For consideration of Financial Assistance, submission of 2016 IRS Form 1040 is required.

*****Non-refundable Deposit of $25 per week attending required once notified of acceptance.**
Deposit will be applied towards tuition.

I/we choose to enroll_____in The Arc of San Antonio's Summer Teen Adventure Club for the following weeks:

_____Just Sports! (6/11/18-6/15/18)

_____Animal Adventure Camp (6/18/18-6/22/18)

_____Rock N Roll SA (6/25/18-6/29/18) (this week is specifically designed for individuals requiring more physical assistance)

_____Ocean Life Camp (7/9/18-7/13/18)

_____Lights, Camera, Action! (7/16/18-7/20/18)

Total number of weeks attending: _____ x $25.00 = _____ Total Deposit Due upon notice of acceptance

-AND-

Total number of weeks attending: _____ x $225.00 = _____ Total Remaining (less deposit) Due by: May 18th, 2018 (upon acceptance)

Inquiries about payments and financial assistance can be directed to:
Mary Longoria
Finance Dept.
210-490-4300 ext. 111

Education Information Request

Name:_____ Date of Birth:_____

TO WHOM IT MAY CONCERN:

I hereby authorize_____
(School, Agency, Etc.)

to forward a copy of the following:

(X) Medical Records / Immunization Records

(X) Most Recent Behavior Management Plan

(X) Updated Individual Education Plan (IEP)

(X) Educational Evaluations / Psychological Evaluations

( ) Other (Specify)_____

I authorize The Arc of San Antonio Director to visit my child at their school:
(x) Yes ( ) No

The contact name and phone number for the school is:
_____
_____

Authorization: I have read and understand the above request and voluntarily consent to the release of records and/or visitations. I understand that this consent may be revoked in writing at any time.

_____ _____
Signature of Parent or Guardian Date

Name of Applicant_____

PRN LIST

The following "PRN" (as needed) medications will be available at The Arc of San Antonio STAC Program. Discuss with your physician which, if not all, are appropriate. If you object to any of these medications, then please make one line through the medication and date and initial. Please sign at the bottom to acknowledge this list, and make sure the physician signs also. Should you need other PRN medications, or a different dose than specified, then you must bring in a physician's order and the medication that is being prescribed in it's original container or blister pack.

Medication	***Used for…..***	***Dosage***	***Calls to Home/Nurse***
Acetaminophen 500mg	Fever/Pain	1 - 2 tabs q 6 hrs. Ages 12+ only.	Call home to ensure not already taken. Call nurse for fever.
Ibuprofen 200mg	Fever/Pain	1 to 2 tabs q 6 hours - Ages 12+ only	Call home to ensure not already taken. Call nurse for fever.
Pink Bismuth (Pepto-Bismol) Regular Strength	Heartburn, Indigestion, Nauseam upset stomach,	Ages 12+ yrs only; 2 Tbsp.(30 ml) q 1 hr. X 2 doses	Call prior to assisting with dose. If diarrhea continues after two doses.
Peroxide	Cuts, Scrapes	Apply a small amount over the wound using a cotton ball	Basic First aid
Triple Antibiotic Ointment	Cuts, Scrapes	Apply a small amount to scrape/cut	Basic First Aid
Hydrocortisone Cream	Bug Bites	Apply a thin layer to itching skin	Call if not effective.

_____ _____

Signature of Physician Date

I acknowledge the above PRN medications are offered at The Arc of San Antonio. I understand that the guidelines above will be followed while at The Arc. Should a need other treatments or medications arise, I must supply The Arc with an order from my physician, as well as the medication prescribed in its original container.

_____ _____

Signature of Parent/Guardian Date

Name of Applicant_____

Physician Medication Order

Please assist: _____ DOB: _____

With taking the following medication(s) or administer checks: _____

_____

_____

Condition for Use: _____

_____

Dosage and special instructions for medication (please include any concerns or special monitoring): _____

_____

Time to be taken: _____ Days to be taken: _____
Prescription Date:_____ Continue this Medication Until:_____

Prescribing Physician (Name and Number):

_____ _____
Physician's Signature *Date*

This order will expire *one year* from the date signed, unless otherwise stated by physician. Please feel free to contact our Nurse with any questions or assistance needed at: 210-490-4300 x 138 or Fax at 210-490-5585.

Medication must be in its original and current container (may use a school dose bottle supplied by the pharmacy) with person's name clearly printed and with the current dose instructions.