APPLICATION PACKET

Yay! Camp Fort Collins _____ Yay! Camp Summit___ YAY! Camp ____
Please check program

Dear Family and Camper,

We would like to welcome you to Easter Seals Colorado Day Camp! We are looking forward to a fantastic summer!

The enclosed forms *must* be completed and returned by mail *prior* to your child attending either day camp. This packet is required of all participants at this time. If you require additional copies, visit our website at www.eastersealscolorado.org.

In addition to the forms, the annual registration fee of $25/child must be submitted with your application. Please write checks payable to **Easter Seals Colorado**.

Day Camp fees for the 2014 summer:
Yay! Camp Summit is $65 per day.
Yay! Camp Fort Collins and Yay! Camp is $75 for campers who require 1:1 ratio, $65 for campers that require a 2:1 ratio or higher per day. Camperships may be available. ***See Attached Flyer***

Day Camps will provide snacks for each child. You will be required to provide a lunch. Days will run from, 8:30am – 4 pm, extended hours must be arranged prior to day of camp and will have additional fees depending on time needs.

An attachment is provided listing available dates. Please mark the dates you are planning on attending.

Please use the following checklist to verify that all information has been submitted.
_____ Day Camp Application
_____ Days attending (see attachment)
_____ $25 onetime non-refundable Registration Fee for 2014
_____ Copy of Medicaid/Medicare/Insurance Card
_____ Recent Photo of the Child
_____ Participant Health Profile
_____ Immunization Record
_____ Seizure Action Plan (if applicable)
_____ Asthma Action Plan (if applicable)
_____ Behavioral Modification Plan from the school (if applicable)
_____ Emergency Sheet
_____ HIPAA Waiver
_____ Authorization for the Administration of Medication -- one form for *each* medication to be given at Day Camp is required. Each child must have one form for sunscreen (unless the child has an allergy or adverse reaction to sunscreen noted in the list of allergies). Without sunscreen a child will not be allowed to play outside.

If you have questions, please feel free to contact us by phone or email. We would be happy to answer any question you may have regarding Day Camps.
See you soon!

Roman Krafczyk
Vice President Program
303-233-1666 ext 235
romank@eastersealscolorado.org

Jesse Macphail
Yay! Camp Summit
303-569-2333 x 0
summit@eastersealscolorado.org

Dawn Michael
Director of YAY! Camp
303-233-1666 ext 235
dmichael@eastersealscolorado.org

XXXXX XXXXXX
Director of Yay! Camp Fort Collins
303-233-1666 x 235
romank@eastersealscolorado.org

Easter Seals Day Camps / Discovery Club Application

Participant Information

Participant Name: _____
First Middle Last

Nickname: _____ Date of Birth: _____ Gender: _____ Ethnicity: _____

Primary Diagnosis: _____

_____

_____

Secondary Diagnosis: _____

_____

_____

Funding Policy

_____ I have read and understand the Funding Policy.

☐ Self Pay ☐ Agency Funding ☐ Scholarship

The Camper's fees will be paid by:

Parents Guardians Self Agency CCB Other:_____

The Camper's bill should be sent to:

Contact Person/Title:_____

Mailing Address:_____

City_____ State _____ Zip_____

Phone Number_____ Fax Number_____

Check the following that apply:

_____ I will pay the full camp fee. (Payment is due by the week prior to the attending week)

_____ I will be partially/ fully funded by an Agency or CCB.

No refunds will be made if camper leaves camp because of behavior problems or is sent home by the camp director.

To pay by credit card, circle one: Visa MasterCard

Cardholder's Name (PRINT) _____

Account Number _____

Expiration Date_____ CID #_____
(3 Digit Security Code on the back of your card.)

Cardholder's Signature:_____

Amount to be charged:_____ Billing Zip Code for Card:_____

☐ **Provide documentation if alternative funding, other than self pay, is used for the participant.**

_____ _____
Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Medical Insurance

Insurance Name _____ Policy/Group Number _____

Medicaid Number _____ Medicare Number _____

☐ **Provide a copy of the Insurance/Medicaid/Medicare Card to be used for urgent care and/or emergency services only.**

☐ **Provide a recent photo for identification of the participant.**

Parent/Legal Guardian #1 Name:

Physical Address: _____

_____

Home Phone: _____ Cell Phone: _____

Employer: _____ Employers Address: _____

Work Phone:_____ Extension: _____

Email: _____

Parent/Legal Guardian #2 Name:

Physical Address: _____

_____

Home Phone: _____ Cell Phone: _____

Employer: _____ Employers Address: _____

Work Phone:_____ Extension: _____

Email: _____

Is anyone not allowed to pick up the child from Day Camp/ Discovery Club?

☐ No ☐ Yes

If yes, please specify: _____

_____

Emergency Contacts
In the event the parent/legal guardian cannot be contacted, an emergency contact will be called. Emergency contacts must show valid picture identification when picking up the child. Only those people listed below, in addition to the parent/legal guardian, may pick up the child.

Emergency Contact #1 Name: _____
First Last

Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Emergency Contact #2 Name: _____
First Last

Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Emergency Contact #3 Name: _____
First Last

Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Pick-Up Policy/ Late Pick-Up Policy/Sick or Behavioral Pick-Up Policy
I understand the participant will only be released to a Parent, Legal Guardian, or Emergency Contact. An Emergency Contact must have valid picture identification for the child to be released. Participants are to be picked up no later than 4:00pm (unless otherwise arranged). The child may not return to the program if two or more late pick-ups occur. Sick participants or participants experiencing behavioral issues must be picked up within one hour of the notification call.

I have read and understand the Pick-Up Policy and will abide by such policy to ensure the safety of all participants.

_____ _____
Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Medications
A complete medication profile is necessary in the event of an emergency. Include all prescribed and over the counter medications the participant may take (even while not attending Easter Seals Colorado) including creams, sunscreens, acetaminophen, and ibuprofen.

Medication #1:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #2:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #3:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #4:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #5:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #6:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #7:_____ Dose: _____

Times given: _____ To be given at Day Programs: No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication Policy
Day Program staff may only administer medications under the direction of the participant's physician. All medications must be given to the Discovery Club Nurse/ Day Camp Directors for safe storage.

Prescribed medications must be in the original container and include the original pharmacy label.

Over the counter medications (such as diaper creams, sunscreens, Tylenol for headaches, etc.) must be in the original container. A written prescription from the health care provider for the medication must be on file. The medication will be given only for the reason prescribed by the health care provider.

I understand that I must supply Day Programs with any prescribed or over the counter medications to be given to the participant.

All documented prescriptions from the health care provider will remain valid for one year, unless otherwise noted by the health care provider. Medications expired per the manufacturer or pharmacy label cannot be given to the participant. I understand that medication will be destroyed if not picked up within one month following the last program day attended.

I have read and understand the Medication Policy and hereby request medications to be administered by Day Program personnel.

_____ _____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Participant Health Profile

Participant Name: _____
First Middle Last

Nickname: _____ Date of Birth: _____ Gender: _____

Primary Diagnosis: _____

_____

_____

Secondary Diagnosis: _____

_____

_____

Surgeries/Dates: _____

_____

_____

Food Allergies: _____

What Happens: _____

Treatment Required: _____

Environmental Allergies: _____

What Happens: _____

Treatment Required: _____

Medication Allergies: _____

What Happens: _____

Treatment Required: _____

☐ **Provide a copy of the updated immunization record**

Communication/Speech

☐ Verbal ☐ Nonverbal ☐ Gestures ☐ Sign Language

Augmentative Communication Device/Adaptive Device

☐ Communication Board ☐ Dynavox ☐ Fingerspelling

Special Instructions _____

_____

_____

Hearing

☐Normal ☐Partially Impaired ☐Total Loss

Adaptive Devices

☐Hearing Aid (site: _____) ☐Cochlear Implant (site:_____)

Special Instructions _____
_____
_____

Vision

☐Normal ☐Impaired ☐Blind

☐Right Eye ☐Left Eye ☐Both Eyes

Adaptive Devices

☐Glasses ☐Patch ☐Contacts

Special Instructions _____
_____
_____

Mobility

☐Walks ☐Scooter ☐Wheelchair ☐Crutches ☐Cane ☐Walker ☐Other: _____

Adaptive Devices

☐Helmet ☐Braces (site: _____) ☐Prosthesis (site: _____)

Special Instructions _____
_____
_____

Transfers

☐No Assist ☐Standby ☐Pivot ☐Two-Person Assist ☐Total Assist

☐Weight Bearing ☐Non-Weight Bearing

Adaptive Devices

☐Lift ☐Gait Belt ☐Body Sling

Special Instructions _____
_____
_____

Feeding

☐No Assist ☐Partial Assist ☐Total Assist

Diet

☐Regular ☐Soft ☐Pureed ☐Liquid ☐Special Diet/Restrictions: _____

Adaptive Devices

☐Gastrointestinal Tube ☐ Nasogastric Tube

☐ Formula Feedings (type: _____ amount: _____ times to be given: _____)

☐ Free Water (amount: _____ times to be given: _____)

Check Residuals Feeding Pump Gravity Feed

☐ No ☐ Yes ☐ No ☐ Yes (rate: _____) ☐ No ☐ Yes

Special Instructions _____
_____
_____

Hand and Face Washing

☐ Normal ☐ Partial Assist ☐ Total Assist

Special Instructions _____
_____
_____

Toileting

☐ Normal ☐ Incontinent (bowel, bladder, both) ☐ Needs Reminders ☐ Catheter

Surgical Diversion

☐ Ostomy ☐ Mitrafanoff ☐ Foley

Toileting Aids

☐ Diapers/Briefs ☐ Urinal ☐ Catheter ☐ Tampons/Pads ☐ Wet Wipes

Schedule/Frequency/Special Instructions _____
_____
_____

Dressing

☐ Normal ☐ Partial Assist ☐ Total Assist

Types of Latches Needing Assist

☐ Buttons ☐ Zippers ☐ Snaps ☐ Velcro ☐ Shoe Laces

Special Instructions _____
_____

Seizures

☐ No ☐ Yes

☐ **If yes, submit the Seizure Action Plan completed by health care provider**

Type of Seizure _____

Date of Last Seizure _____

Describe the seizure activity _____
_____
_____

Describe the postictal phase _____
_____
_____

Asthma/Reactive Airway Disease

☐No ☐Yes

☐**If yes, submit the Asthma Action Plan completed by health care provider**

Oxygen Use

☐No ☐Yes (prescription from the health care provider must be on file)

Adaptive Devices

☐ Nasal Cannula ☐Mask

☐ Flow Rate/Flow Range _____

Monitoring

☐ Pulse Oximeter (parameters _____ to _____)

In the past year has there been any history of behaviors that are inappropriate or destructive/dangerous to self, others, or property?

☐**If yes, submit the Behavioral Modification Plan.**

Describe the behaviors _____
_____
_____
_____

Does your child have history of running away or wandering?

☐No ☐Yes

** All Campers must submit a current immunization record prior to attending camp.**

The Participant Health Profile is used to determine if the participant's needs (physically, developmentally, and emotionally) may be safely met by Easter Seals Colorado Programs. The information provided is accurate and true to the best of my knowledge.

_____ _____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Acute Illness Exclusion
Easter Seals Colorado wants to maintain a healthy environment for all its participants and staff and requests no child with acute illness attend any program.

_____ _____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

Exclusion Policy Based on Needs
If the child's needs exceed the service capacity of the program, the child may be excluded from the program.

_____ _____

Signature of Parent/Legal Guardian #1/Date **Signature of Parent/Legal Guardian #2/Date**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION
AT EASTER SEALS COLORADO DAY CAMPS/ DISCOVERY CLUB

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication.

Complete *one form* for *each medication* to be administered at Easter Seals Colorado Day Programs, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Use for Prescriber's Stamp

Prescriber's Signature: _____ Date: _____

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Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Use for Prescriber's Stamp

Prescriber's Signature: _____ Date: _____

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Complete *one form* for *each medication* to be administered at Easter Seals Colorado Day Programs, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

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Name of Participant: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Use for Prescriber's Stamp

Prescriber's Signature: _____ Date: _____

Emergency Sheet

Name: _____ Program/Site: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Allergies (medications, food, and/or environmental). Describe; if none please write no allergies:

_____

_____

Current medications:

_____

_____

List any health conditions that may have implications for emergency care:

_____

_____

Emergency Contact #1: Name/Phone Number/Relationship/ Address:

_____

Emergency Contact #2: Name/Phone Number/Relationship/ Address:

_____

Medical Contact Information:

Doctor Name: _____ Phone Number: _____

Preferred Hospital/ Address and telephone number:

_____

Dentist Name: _____ Phone: _____

Address: _____

☐ I have voluntarily provided the above contact information and authorize Easter Seals Colorado and its representatives to contact any of the above on my behalf in the event of an emergency. **I also give permission for Easter Seals Colorado to seek medical assistance in the event of a medical emergency for my child.**
Signature of Participant/ Parent / Guardian

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/ PARTICIPANT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your/ participant protected health information, to notify you of our legal duties and privacy practices with respect to your/ participant health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your/ participant rights concerning your/ participant information. Our duties and your/ participant rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your/ participant health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your/ participant information for purposes of treating you/ participant. For example, we may disclose your/ participant information to another health care provider so they may treat you/ participant; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your/ participant information to obtain payment for services provided to your/ participant. For example, we may disclose information to your/ participant health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your/ participant information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your/ participant information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your/ participant information as described below.

- To a member of your family, relative, friend, or other person who is involved in your/ participant healthcare or payment for your/ participant healthcare. We will limit the disclosure to the information relevant to that person's involvement in your/ participant healthcare or payment.
- To maintain our facility directory. If a person asks for you/ participant by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.
- To contact you/ participant to raise funds for Easter Seals Colorado. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your/ participant health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your/ participant care or payment for your/ participant care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you/ participant or others.

- You may request that your/ participant protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your/ participant protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your/ participant privacy rights have been violated. You may file a complaint with us by notifying Nancy Hanson. All complaints must be in writing. We will not retaliate against you/ participant for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

NANCY HANSON
VICE PRESIDENT OF HUMAN RESOURCES
303-233-1666 X 237
5755 WEST ALAMEDA AVE
LAKEWOOD, CO 80226
NHANSON@EASTERSEALSCOLORADO.ORG

_____ _____
Name Signature

_____ _____
Parent/Guardian name Signature

8. Effective Date. This Notice is effective _____, 20_____.

Agreement, Consent and Release:

With the understanding that Easter Seals Colorado will make every reasonable effort to prevent accidents, injuries or other mishaps, I acknowledge the following:

_____ (initial) The undersigned agrees to indemnify and hold harmless Easter Seals Colorado – Day Camps for any and all claims, demands, costs, expenses, including reasonable attorney's fees that Easter Seals Colorado may suffer as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the Easter Seals Colorado from any act of negligence or fault on the part of Easter Seals Colorado, its officers, agents or employees.

_____ (initial) The undersigned does consent that photographs, video or motion pictures may be taken of the named applicant during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, web site, publicity releases and/or other media.

_____ (initial) The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

_____ (initial) The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted).

_____ (initial) The undersigned gives permission for the applicant to ride in vehicles operated or leased by the Easter Seals Colorado.

_____ (initial) The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health and safety at camp. The undersigned further agrees to pick up the camper immediately upon being notified of such termination. Full camp fees are nonrefundable in case of above mentioned situations.

_____ (initial) The undersigned agrees to pay the full camp fee if the camper cancels one week or less prior to the check in day. This includes not arriving on check in day.

_____ (initial) The undersigned agrees not to send the applicant to Easter Seals programs if he or she has been exposed to a contagious disease within three (3) weeks of the starting date of camp, and to notify Camp Director if this situation arises.

_____ (initial) Weapons, pets, drugs and alcohol are not allowed at Summer Day Camp. An exception may be made for trained guide dogs for campers who require their services. The dog's owner assumes all responsibility for the care and actions of the dog. The dog must be free of disease and have a current rabies license or tag. Dogs that exhibit any behaviors that put Easter Seals' staff, campers or visitors at risk will not be permitted to remain. Costs to have the animal removed from the camp will be at the owner's expense. A copy of the dog's vaccines is required.

- If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned. I do hereby authorize to pick up camper. _____

_____ _____ _____ _____

(Name) *(Address)* *(City)* *(State)*

• Please list anyone in particular you do NOT want to pick up your child or adult. _____

• In witness where of I have here unto executed this Agreement, Consent & Release on this date:

LEGAL GUARDIAN'S SIGNATURE:_____Date: _____

LEGAL GUARDIAN'S PRINTED NAME:_____

Demographics Information

This information will be compiled and used for reports to Easter Seals National, foundations, and for grant applications. Actual camp costs are $100/day per camper. To keep costs for each camper at the current rate, this information is needed to receive donations, contributions, and for grant purposes.

This information is in regards to the camper: (Please check the correct information).

Education:

- Less than 12 yrs
- High School grad or GED
- Some College or Assoc. Degree

Ethnicity:

- Asian American
- African American
- Caucasian
- Hispanic
- Native American
- Multiple Ethnicities

Household Income:

- Less than $10,000
- $10,000 - $ 14,999
- $15,000 - $ 24,999
- $25,000 - $34,999
- $35,000 - $ 49,999
- $50,000 - $ 74,999
- $75,000 - $ 99,999
- $100,000 - $149,000
- $150,000 - $199,999
- $200,000 and above

Household count _____ (If the camper is in a group home or host home, only the camper's information is required. If the camper is still living at home, total household count and income is required.

YAY! CAMP ATTACHMENT

PLEASE CHECK THE DAYS YOU ARE PLANNING ON ATTENDING.

LOCATION: 8997 South Broadway Ave. Highlands Ranch, CO 80129 (Christ Lutheran Church)

Please check the following dates the camper will be attending YAY! Camp:

__ June 9 __ June10 __ June 11 __ June 12 __ June 16 __ June 17

__ June 18 __ June 19 __ June 23 __ June 24 __ June 25 __ June 26

__ June 30 __ July 1 __ July 2 __ July 3 __ July 7 __ July 8

__ July 9 __ July 10 __ July 14 __ July 15 __ July 16 __ July 17

__ July 21 __ July 22 __ July 23 __ July 24 __ July 28 ___ July 30

___ July 31

Financial reminder:

Cost is $75 per day for campers that require a 1:1 ratio and $65 per day for campers that require 2:1 ratio or higher. (Payment is due by the week prior to the attending week)

Developmental Pathways has scholarship funding for residents of Arapahoe and Douglas Counties who are receiving no services through Developmental Pathways.

For more information to see if you qualify contact:

Barb Komdat	**or**	**Deb Bosch**
303-858-2327		**303-858-2004**
303-434-8947		**303-434-9384**

YAY! CAMP SUMMIT COUNTY ATTACHMENT

PLEASE CHECK THE DAYS YOU ARE PLANNING ON ATTENDING.

LOCATION: 110 3rd Ave. Frisco, CO 80443

Please check the following dates the camper will be attending Summit County Day Camp

__ June 9	__ June 10	__ June 11	__ June 16
__ June 17	__ June 18	__ June 23	__ June 24
__ June 25	__ June 30	__ July 1	__ July 2
__ July 7	__ July 8	__ July 9	__ July 14
__ July 15	__ July 16	__ July 21	__ July 22
__ July 23	__ July 28	__ July 29	__ July 30
__ Aug. 4	__ Aug. 5	___ Aug. 6	

Financial reminder:

Cost is $65 per day (Payment is due by the week prior to the attending week)

YAY! CAMP FORT COLLINS ATTACHMENT

PLEASE CHECK THE DAYS YOU ARE PLANNING ON ATTENDING.

LOCATION: EDUCATION BUILDING B105 CSU CAMPUS

Please check the following dates the camper will be attending Yay! Camp FTC:

__ June 9 __ June10 __ June 11 __ June 12 __ June 16 __ June 17

__ June 18 __ June 19 __ June 23 __ June 24 __ June 25 __ June 26

__ June 30 __ July 1 __ July 2 __ July 3 __ July 7 __ July 8

__ July 9 __ July 10 __ July 14 __ July 15 __ July 16 __ July 17

__ July 21 __ July 22 __ July 23 __ July 24 __ July 28 ___ July 30

___ July 31

Financial reminder:

Cost is $75 per day for campers that require a 1:1 ratio and $65 per day for campers that require 2:1 ratio or higher. (Payment is due by the week prior to the attending week)