

LYNN SPECIAL NEEDS CAMP

250 COMMERCIAL STREET

LYNN, MA 01905

781-477-7096

LSNC01905@YAHOO.COM

2011 CAMPER APPLICATION

CHILD'S NAME: _____		Date of Birth: ____ / ____ / ____
Sex: _____	Age: _____	Ethnic Group (Please check one) <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian
Social Security #: _____ - _____ - _____		
Place of Birth: _____		
Language Spoken at Home: _____		
Home Address: _____		City, State, Zip Code: _____

FATHER'S NAME: _____	
Home Address: _____	City, State, Zip Code: _____
Home Phone Number: _____	Cell Phone Number: _____
Place of Employment: _____	Work Phone Number: _____

MOTHER'S NAME: _____	
Home Address: _____	City, State, Zip Code: _____
Home Phone Number: _____	Cell Phone Number: _____
Place of Employment: _____	Work Phone Number: _____

Name of Legal Guardian: _____

Will your child need transportation?: _____ YES _____ NO ** Transportation Provided To Lynn Residents Only. **

Please check off your combined family income (We must have this information for administrative purposes only):

\$0 - \$9,999 _____

\$10,000 - \$19,999 _____

\$20,000 - \$29,999 _____

\$30,000 - \$39,999 _____

\$40,000 - \$49,999 _____

\$50,000 & Up _____

Total Household Size (How Many Live In House): _____

Please List Two (2) Emergency Contacts (Other than Mother/Father)

1. Name: _____

Relationship to the Child: _____

Address: _____

City, State, Zip Code: _____

Cell Phone: _____

Home Phone: _____

2. Name: _____

Relationship to the Child: _____

Address: _____

City, State, Zip Code: _____

Cell Phone: _____

Home Phone: _____

Social Worker/Therapist Name: _____

Name of Agency: _____

Work Phone: _____

Address: _____

City, State, Zip Code: _____

**** PLEASE NOTE ****

***In order for your child to leave camp premises with any person,
we need to have WRITTEN permission from the legal guardian.***

I, _____, give my permission:

1. For my child to attend field trips under staff supervision that will require travel off camp premises within Massachusetts.
YES _____ NO _____
2. To provide required health records.
YES _____ NO _____
3. For the Lynn Special Needs Camp staff to the bus/van for pickup, and meet the bus/van when my child is brought home.
YES _____ NO _____
4. For my child to be transported in program vehicles, including the Camp Vans.
YES _____ NO _____
5. For my child to be photographed – photographs that may be used to describe programs, recognize accomplishments, and/or public relations.
YES _____ NO _____
6. For my child to be included in video recordings that may be prepared for in-service training, orientation, and/or public relations.
YES _____ NO _____
7. For my child's name to be published in a Camp newsletter and/or the local newspaper.
YES _____ NO _____

Signature of Parent/Guardian: _____

Date: _____

SKILLS AND BEHAVIOR CHECKLIST

What recreational activities does your child enjoy?

Track & Field	_____	Sewing	_____	Field Hockey	_____
Soccer	_____	Painting	_____	Crafts	_____
Baseball	_____	Coloring	_____	Basketball	_____
Cooking	_____	Nature	_____	Hiking	_____
Gardening	_____	Skating	_____	Swimming	_____
Music	_____	Dancing	_____	Drama	_____

Others: _____

Are there any adaptations that we should make to assure your child's participation in Camp activities? _____

Are there any activities in which you would like us to try, and encourage your child's participation? _____

Please state your child's swimming ability and attitude toward water. _____

Toileting Skills:

Completely trained	_____	Has few accidents if toileted regularly	_____
Trained but has occasional accidents	_____	Not toilet trained	_____

Social & Behavioral Checklist:

	YES	NO
Active member in a group	_____	_____
Is a good sport	_____	_____
Can complete a game	_____	_____
Tires quickly of one game	_____	_____
Enjoys being a helper	_____	_____
Enjoys games with set rules	_____	_____
Able to care for belongings	_____	_____
Prefers to play with adults	_____	_____
Prefers to play alone	_____	_____
Participates in team games	_____	_____
Is shy with adults	_____	_____
Cannot follow rules	_____	_____
Plays cooperatively with others	_____	_____
Will conform to group rules	_____	_____
Requires close adult supervision	_____	_____
Lacks discipline	_____	_____
Has been kept close to home	_____	_____
Will stray from group if not closely supervised	_____	_____

MEDICAL HISTORY FORM

Child's Name: _____

Please provide us with a list of doctors, neighborhood health centers, clinics, etc., where your child currently receives care – with phone numbers to all, please:

Doctor's Name: _____ Phone #: _____

Health Center: _____ Phone #: _____

Any additional: _____ Phone #: _____

Family History

Father's D.O.B.: ____ / ____ / ____ State of Health: _____

Mother's D.O.B.: ____ / ____ / ____ State of Health: _____

Siblings

Name:	Birthdate:	Sex	State of Health
_____	____ / ____ / ____	____	_____
_____	____ / ____ / ____	____	_____
_____	____ / ____ / ____	____	_____
_____	____ / ____ / ____	____	_____

Does anyone in your family have

	YES _____	NO _____	Relationship to Child
Diabetes?	YES _____	NO _____	_____
Allergies/Asthma?	YES _____	NO _____	_____
Heart Disease?	YES _____	NO _____	_____
Kidney Disease?	YES _____	NO _____	_____

Are there any other diseases that run in the family? YES _____ NO _____
If yes, please explain: _____

CHILD'S MEDICAL HISTORY

Has your child had:

Measles? YES _____ NO _____

German Measles? YES _____ NO _____

Mumps? YES _____ NO _____

Chicken Pox? YES _____ NO _____

Rheumatic Fever? YES _____ NO _____

Other(s): _____

Were there any complications from any of these diseases? YES _____ NO _____

If yes, please explain: _____

Do you carry Family Medical/Hospital Insurance: YES _____ NO _____

Name of Carrier: _____

Policy/Group #: _____

<u>Physical Conditions</u>

Does your child have any physical conditions which would interfere with Camp activities? _____

Does your child use: BRACES _____ WALKER _____ WHEELCHAIR _____

Does your child experience SEIZURES? YES _____ NO _____

If YES, are they controlled by medicine? _____

What type of medication? _____ Dosage: _____

Does your child wear glasses? _____ Hearing Aids: _____

WILL YOUR CHILD REQUIRE MEDICATION DURING CAMP HOURS? _____

(If yes, please discuss with Camp Director / Nurse)

Medication: _____ **Dosage:** _____

Hours Medication Given: _____ **How many times daily?** _____

If female, has your child begun menstruation? _____

<u>Bones, Joints, Muscles, Skin</u>

Deformities, swelling: _____

Redness or tenderness: _____

Scars, abrasions, or sores: _____

Limitation of motion, coordination: _____

IMMUNIZATIONS
Must be up to date – See attached form

Allergies

Is your child allergic to any food or drug? YES _____ NO _____

If YES, what is he/she allergic to? _____

What is the child's allergic reaction? _____

Injuries and Operations

Has your child ever suffered from a major injury or illness which required hospitalization?

YES _____ NO _____

If yes, please explain: _____

Has your child ever undergone surgery?

YES _____ NO _____

If yes, please explain: _____

Chronic Conditions

Is your child currently being treated and/or take medication for a condition?

YES _____ NO _____

If yes, please explain: _____

What medication: _____

Current Condition: _____

Lynn Special Needs Camp
Recreation Center for Children with Special Needs

TEACHER'S STATEMENT

(To be filled out by child's current teacher)

Child's Name: _____

In an effort to provide each child with the opportunity to experience a continuous educational program, please make suggestions in the following areas for the above mentioned child so that we may understand what level the child is at when we plan our recreational activities.

Gross Motor Skills: _____

Fine Motor Skills: _____

Self-Help Skills: _____

Sensory Skills: _____

Social Skills: _____

Communication Skills: _____

Functional Academic Skills: _____

Behavior Management Techniques: _____

Additional Comments (Use back if necessary): _____

Teacher's Signature: _____

Date: ____ / ____ / ____

Teacher's Name: _____

School: _____

City/Town: _____

Phone Number: _____