



PO Box 1222
 Lafayette, IN 47902-1222
 765-476-3277
 www.arcoftippecanoe.org



campsparks@arcoftippecanoe.org
 www.arcoftippecanoe.org/campsparks

It's time for 2015's Camp S.P.A.R.K.S. (Special Play and Recreation for Kids with Special needs), a summer recreation program for children with special needs ages 5 - 17 and their siblings!

Dates: Monday June 22nd - July 17th (Mon - Fri each week)
Time: 1:00pm - 5:00pm
Place: Linwood Elementary
Application fee: \$25 (Non-refundable deposit to be deducted from camp fee)
Cost: \$280 per camper (scholarships available—see below)

Checks payable to: The Arc of Tippecanoe County. \$25 returned check fee.

To register, please complete the attached forms and return them by **May 22nd** to:
 Camp S.P.A.R.K.S.
 The Arc of Tippecanoe County
 P.O. Box 1222
 Lafayette, IN 47902-1222

Scholarship Information: There are a limited number of scholarships for which families may apply. Scholarships may or may not be available based on availability of funds. If you would like to be considered for a scholarship based upon financial need, number of campers attending or communication disorder, check the appropriate box below. Scholarship awards will be made at the end of May if funding allows.

- My child's IEP includes a communication disorder or impairment as either the primary or secondary disability under the eligibility section. Please provide a copy of your child's IEP.
- I would like to apply for a scholarship based upon my family size and household income.
- I would like to apply for a scholarship based upon the number of children I will be sending to Camp SPARKS this summer. We strongly encourage siblings of children with special needs to also attend camp! Total number of children in your family you are planning to register: _____

Space is limited & camp is filled as registrations are received. Registration is complete only when the registration form, physician's release and camp fee are received.

Please remember that Camp S.P.A.R.K.S. does not provide transportation or one-on-one assistance. If you believe that your child requires one-on-one assistance, please arrange for a provider to be with your child. If your child attends camp without assistance and it is determined that he or she cannot attend safely, the camp director will not allow the child to return until one-on-one assistance is provided, which is the responsibility of the parent to find a suitable person for.

Parent's Orientation Meeting will be held early in June. Date, time and location to be announced. A Parent Handbook and a schedule of events will be provided, along with discussion on camp policies and procedures. Families will receive more information on the parent meeting after registration is received.

We have many exciting, educational, social and recreational activities planned for this summer and hope your child will be there with us! If you have any questions, please feel free to call us at 765-476-3277 or send email to campsparks@arcoftippecanoe.org.



2015 Camp S.P.A.R.K.S. Registration
Please complete for each child attending Camp SPARKS

campsparks@arcoftippecanoe.org
www.arcoftippecanoe.org/campsparks

Child's Name: _____ Phone: _____

Child's Address: _____
(Street, City, State, Zip)

Gender: Female Male Age: _____ Birthday: ____ - ____ - ____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

***Email Address: _____

Would you like a free membership to The Arc of Tippecanoe County to learn about upcoming events and other information relevant to people with intellectual/developmental disabilities? yes no

Emergency Contacts (used if neither Parent/Guardian listed above can be reached):

Name: _____ Phone #: _____

Name: _____ Phone#: _____

Parent Permission

I give my permission for my child to participate in The Arc of Tippecanoe County's **Camp S.P.A.R.K.S.** program, including swimming and field trips that are offered during the summer of 2015. I will not hold The Arc of Tippecanoe County or any of its employees or volunteers liable for any injuries that may occur during participation in the camp or in transit to and from an activity.

Signature of Parent/Guardian: _____ Date: _____

Photo Release

This is to indicate that I (*please circle*) **do** / **do not** grant permission for any photographs to be taken of my child while participating in activities connected with **Camp S.P.A.R.K.S.** that will be used for any purpose by The Arc of Tippecanoe County. Photos may be taken at times for newspapers, television, brochures, or professional publication.

Signature of Parent/Guardian: _____ Date: _____

List the disabilities on your child's IEP or as diagnosed by the doctor (check ALL that apply):
(may not apply to siblings). **Please provide a copy of your child's IEP with your registration.**

- | | | |
|---|---|---|
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Language/Speech Impairment | <input type="checkbox"/> Blind/Low Vision |
| <input type="checkbox"/> Emotional Disability | <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Cognitive Disability | <input type="checkbox"/> Multiple Disabilities | <input type="checkbox"/> Orthopedic Impairment |
| <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> N/A Sibling without disabilities |

Race:

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Hispanic/Latino/Chicano | <input type="checkbox"/> Multi-Racial | <input type="checkbox"/> Other Ethnic Designation | _____ |

Current Household Income Level:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Under \$15,000 | <input type="checkbox"/> \$15,000-\$24,999 | <input type="checkbox"/> \$25,000-\$34,999 | <input type="checkbox"/> \$35,000-\$49,999 |
| <input type="checkbox"/> \$50,000-\$74,999 | <input type="checkbox"/> \$75,000-\$99,999 | <input type="checkbox"/> \$100,000+ | |

Does your child qualify for free or reduced lunches at school:

- Reduced Lunches Free Lunches No

What school did your child attend this year? _____

Who was your child's primary teacher during the school year? _____

May we contact your child's teacher? Yes No

Did your child have a one-on-one aide during the school year? Yes No

Does your child take medications? Yes No If yes, please list kind and amount:

| Medication Name | Amount | Times per day |
|-----------------|--------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*** If camp staff is to administer medications, your child's physician will need to list them on the physician form with their name and the dosage to be administered. The medication must be supplied in a pharmacy bottle and given to the Camp Director.*

Does your child have any allergies? Yes No If yes, please list below with possible reactions:

What is the exact name of your child's disability(ies) or condition(s)?

Please provide a detailed explanation how these conditions/disabilities impact your child during his day:

How independent is your child at toileting procedures:

- Completely Independent Trained but requires assistance in bathroom Wears underwear but has some accidents Wears diaper or pull-up and requires full assistance

Please explain specific to your child:

Does your child have any sensory, physical or medical restrictions: Yes_____ No_____

Please describe:

Describe any behavior challenges that your child may have and the positive discipline strategies or techniques that work with your child.

Does your child have aggressive behavior to others? Please describe:

How does your child communicate? Please check all that apply and describe:

_____ Verbally _____ Sign Language _____ Picture Board _____ Gestures _____ Electronic Device

Is your child's primary language something other than English? If so, describe:

Does your child wear or need any special equipment? (hearing aids, braces, wheelchair, etc.) Please describe:

Is your child able to board a bus independently? Yes No

Does your child wear a harness while riding on the bus? Yes No

******The Arc of Tippecanoe County and Camp SPARK are not liable for any loss or damage to equipment during camp hours and outings. Staff will be diligent in monitoring and protecting equipment but cannot be responsible for accidental breakage or loss.**

Does your child enjoy swimming? ____yes ____no Please describe your child's swimming abilities:

Does your child need help getting dressed and undressed for swimming? Yes ____ No ____

Describe:

Does your child have any special hobbies or interest? What does your child enjoy doing?

Can your child participate in vigorous outdoor or indoor games/sports? Yes No

If no, can you please specify limitations on activities or any activities that must be avoided?

Are there any campers that your child enjoys being with? _____

Is there anything else you wish to tell us about your child that would help camp staff? (Behaviors, activities, and treats they enjoy, motivating items, things staff should watch for etc.). Please feel free to give as much detailed information as you feel is appropriate. Thank you for your help in making Camp S.P.A.R.K.S. a fun experience for your child!!

Please provide 2-3 *specific* goals you would like to see your child working on at camp this year. These could include things such as socialization, trying new things, following rules, participating with a group, improving acceptable behavior across different community setting etc.

- 1) _____

- 2) _____

- 3) _____

For Administrative Use:

Fee Received: _____

If no, what arrangements were made for the fee? _____

Camp Room Assignment: _____

Camp S.P.A.R.K.S. Physicians Release - 2015

Camper's full name: _____

Date of exam: _____

Address: _____

City: _____

Parent/Guardian Name: _____

Address (if different than camper): _____

City: _____

Emergency Contact (other than parent): _____

Address: _____

Health/Accident Company: _____

Date of Birth: _____
(Month, Day, Year)

Gender: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Policy Number: _____

Medical Information

- | | | |
|--|-----|---|
| 1. Heart Disease/Heart Defect/ High Blood Pressure | Y N | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Chest Pain or Fainting Spells | | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Seizures/Epilepsy | | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Diabetes | | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Down Syndrome | | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Absence of vision/blind in one eye | | <input type="checkbox"/> <input type="checkbox"/> |
| 7. concussion or serious injury | | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Major surgery or serious illness | | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Heat Stroke/exhaustion | | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Other problems that would interfere with camp participation | | <input type="checkbox"/> <input type="checkbox"/> |
| List: _____ | | |
| 11. Impaired motor ability | | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Uses a wheelchair | | <input type="checkbox"/> <input type="checkbox"/> |

- | | | |
|---|-----|---|
| 13. Allergy to the following (list specific) | Y N | <input type="checkbox"/> <input type="checkbox"/> |
| 14. Exercise induced wheezing | | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Tendency to bleed easily | | <input type="checkbox"/> <input type="checkbox"/> |
| 16. Special Diet | | <input type="checkbox"/> <input type="checkbox"/> |
| 17. Emotional/psychiatric/behavior Problems | | <input type="checkbox"/> <input type="checkbox"/> |
| 18. Serious bone or joint disorder | | <input type="checkbox"/> <input type="checkbox"/> |
| 19. Hearing aid/hearing loss | | <input type="checkbox"/> <input type="checkbox"/> |
| 20. immunizations (shots) are up-to-date | | <input type="checkbox"/> <input type="checkbox"/> |

Comments: _____

A physical examination form must be completed by a physician each year prior to camp.

MEDICATIONS-Please print medication name, amount, date prescribed and number of times per day medication needs to be taken.

MEDICAL CERTIFICATION

I have reviewed the above health information on and examined the camper named in the application, and certify there is no medical evidence available to me which would preclude the camper's participation in CAMP S.P.A.R.K.S.

Restrictions _____

Examiner's Signature (MUST be a physician) _____

Examiner's Name _____

Address _____

Date _____

Phone _____

Camp SPARKS 2015 Pick-up People

For the safety and security of your child/ren, we at Camp SPARKS would like a list of eligible "Pick-up People". A "pick-up person" is a person/s that you authorize to pick up your child/ren from the program each afternoon. We would like to ensure all your children's safety and security by creating an authorized list of people that you (parents/guardians) designate as the only people allowed to pick up your child/ren from Camp SPARKS. THIS FORM ONLY NEEDS TO BE COMPLETED IF THE PARENTS/GUARDIANS WHO COMPLETED THIS REGISTRATION PACKET IS NOT GOING TO BE PICKING UP THE CHILD/REN. We will ask for your special code word and may request identification from EVERYONE (including parents/guardians) who picks up a child each afternoon, so please inform anyone who may be picking up your child/ren that they will need photo identification and/or the codeword (and so will you!). If you have any questions, please contact the camp director, campsparks@arcoftippecanoe.org or 765-476-3277.

Please provide a copy of the driver's license for all those people that will be authorized to pick up your child with this application

Child/ren's Name/s: _____

Codeword: _____

Pick up Person #1: _____

Relationship to child: _____

Telephone #: _____

Drivers' License #: _____

Pick up Person #2: _____

Relationship to child: _____

Telephone # _____

Drivers' Licensee # _____

Parent Authorization for Emergency Medical Treatment

Camp SPARKS Medical Authorization for Treatment of a Minor (persons under 18 years)

Pursuant to Indiana Code Paragraph 16-36-1-6, I request and authorize Camp SPARKS STAFF, Tippecanoe Ambulance Service, St. Elizabeth East and Clarian Arnett Hospital, medical personnel, agents, and employees to provide all reasonably necessary medical care advisable for the health of my child, including but not limited to medical transport, hospital tests, such as pathology, radiology, anesthesia, evaluation and treatment by physicians, including surgery, and prescription drugs. I acknowledge that no representations, warranties, or guarantees can be made with respect to any medical care or treatment provided.

I also understand that, as a result of my child's participation in this program, it will be necessary for supervisors and others involved with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

Further, I hereby grant permission for my child:

Minor's Name:

To attend the Camp SPARKS 2015 Program by signing below. A signature from one or both parents/legal guardians and a witness signature is required.

Signature Parent/Legal Guardian (required)

_____ Date _____

Signature Parent/Legal Guardian/Witness (required)

_____ Date _____