

Date Received: _____

CAMP ARC



SUMMER CAMP APPLICATION

Personal Data

Child's Name _____

Last

First

Middle

Social Security Number _____

Date of Birth: _____ Sex: ___ Male ___ Female

Child's Address _____

Street

City

State

Zip Code

Home and Family Information

A. Mother/Guardian

Name: _____

Last

First

Occupation: _____ Employer: _____

Phone: work _____ cell _____ home _____

B. Father/Guardian

Name: _____

Last

First

Occupation: _____ Employer: _____

Phone: work _____ cell _____ home _____

Child Lives With _____

Relationship _____

C. Others Living at Home

Name	Age	Sex	Relationship	Attending camp as sibling?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Are there any cultural/religious values that would prohibit your child from participating in any activities or food preparations?

Health, Medical, and Community

1. Pediatrician _____

Name

Phone Number

2. List any operations, illnesses, or injuries your child has had.

_____ Age: _____
_____ Age: _____

3. Does your child have a diagnosed disability? _____

4. Does your child have any allergies? List:

5. Does your child receive any related services such as Speech/OT/PT that will need to continue during summer months?

6. Name any medications that your child is presently taking:

Medication	Dosage	Reason for taking	Time given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Have your child's eyes been checked? _____ Results: _____
8. Has your child's hearing been tested? _____ Results: _____
9. Does your child have any problems with sleeping_____ or eating? _____
10. Has your child had a psychological evaluation? _____ When? _____

Language

1. Do you feel that your child hears well? _____
2. Does your child communicate by: gestures_____ words_____ sentences_____
3. Estimate present vocabulary size:
0-25 words___25-100 words___over 100 words_____

Behavior

1. How does your child get along with siblings/peers?

2. Does your child have any fears? _____
3. What is your child's usual behavior when angry or frustrated?

4. Has your child experienced a traumatic situation that may be related to his/her behavior?

Child's Interest or Hobbies

1. Does you child have any special interests?_____
2. Describe the types of activities that you and your family enjoy doing:

Sonia Prescott

Director of Education/Kid's Corner/Autism Services

sprescott@albanygaarc.org

Sonny Slate

ARC Executive Director

sslate@albanygaarc.org

DeAnna Julian

ARC Deputy Director

djulian@albanygaarc.org