

810-694-0101 Fax: 810-695-0888  
360 E. Grand Blanc Rd  
Grand Blanc, MI 48439

<b>FOR OFFICE USE ONLY</b>		
Date _____	Amt. Pd. _____	By _____
Date _____	Amt. Pd. _____	By _____



**2011 Camp C.A.R.E. ENROLLMENT FORM**

**Please fill out all forms completely.**

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Workplace/Daytime Phone \_\_\_\_\_

Mother's Workplace/Daytime Phone \_\_\_\_\_

Email \_\_\_\_\_

Camper's School \_\_\_\_\_ Teacher \_\_\_\_\_

**In case of emergency, if parent or guardian cannot be reached, please notify:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Company Name

Policy Number

Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

**PRESENT CERTIFICATION** – (Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> MiCI (EMI)        | <input type="checkbox"/> PI (Physically Impaired) |
| <input type="checkbox"/> AI (Autistic)     | <input type="checkbox"/> Learning Disabled        |
| <input type="checkbox"/> General Education | <input type="checkbox"/> Emotionally Impaired     |
| <input type="checkbox"/> Other _____       |   |

**SPECIAL NEEDS**

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Walker     | <input type="checkbox"/> Wheelchair hook-up for bus transportation |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Other _____                               |

Primary Disability \_\_\_\_\_

Date of last Tetanus Booster? \_\_\_\_\_

**Circle T-shirt size** (please circle one):

Youth Sizes: Medium (10-12)    Large (14-16)

Adult Sizes: Small/Medium/Large/X-Large/XX-Large

Is your child on medication? \_\_\_ Yes \_\_\_ No (If yes, fill out Medical Information/Authorization form)  
Please Note: If your child is on medication for behavior during the school year, we ask that they continue during camp.

Does your child have allergies? \_\_\_ Yes \_\_\_ No If yes, to what? \_\_\_\_\_  
\_\_\_\_\_

Does your child carry an Epi pen on them? \_\_\_ Yes \_\_\_ No

**PLEASE CHECK ALL THAT APPLY:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Closed Head Injury      | <input type="checkbox"/> HIV Positive   | <input type="checkbox"/> Normal Function            |
| <input type="checkbox"/> Cerebral Palsy          | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> ADHD / ADD                 |
| <input type="checkbox"/> Spina Bifida            | <input type="checkbox"/> CMV            | <input type="checkbox"/> Learning Disabled          |
| <input type="checkbox"/> Hearing Impaired Oral   | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> MiCI (EMI)                 |
| <input type="checkbox"/> Hearing Impaired Total  | <input type="checkbox"/> Autism         | <input type="checkbox"/> MoCI (TMI).                |
| <input type="checkbox"/> Visually Impaired       | <input type="checkbox"/> Hemophilia     | <input type="checkbox"/> Emotionally Impaired       |
| <input type="checkbox"/> Muscular Dystrophy      | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Communication Difficulties |
| <input type="checkbox"/> Birth Defects           | <input type="checkbox"/> Stroke         | <input type="checkbox"/> SCI (SMI)                  |
| <input type="checkbox"/> Lung/Breathing Problems | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Other, please explain:     |
| <input type="checkbox"/> Hydrocephaly            | <input type="checkbox"/> Scoliosis      | _____   |

Is your child subject to seizures? \_\_\_ Yes \_\_\_ No

**SEIZURES:** \_\_\_\_\_ MILD \_\_\_\_\_ MODERATE \_\_\_\_\_ SEVERE

**SPECIAL NEEDS:**

Is your child in diapers? \_\_\_ Yes \_\_\_ No

Does child need assistance with toileting? \_\_\_ Yes \_\_\_ No If yes, please explain? \_\_\_\_\_  
\_\_\_\_\_

Does child need assistance with eating? \_\_\_ Yes \_\_\_ No If yes, please explain? \_\_\_\_\_  
\_\_\_\_\_

**SPECIAL EQUIPMENT:**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Catheter     | <input type="checkbox"/> Wheel chair - Manual or Electric? _____ |   |
| <input type="checkbox"/> Dentures     | <input type="checkbox"/> Braces                                  | <input type="checkbox"/> Contact Lenses         |
| <input type="checkbox"/> Eyeglasses   | <input type="checkbox"/> Speech Board                            | <input type="checkbox"/> Hearing Aid            |
| <input type="checkbox"/> Eating Tools | <input type="checkbox"/> Walker                                  | <input type="checkbox"/> Prosthesis? Type _____ |
- Other: \_\_\_\_\_  
\_\_\_\_\_

Please explain any special problems or instructions regarding any of the above and be specific:  
\_\_\_\_\_  
\_\_\_\_\_

The staff at C.A.R.E. would really like to get to know your child better and would appreciate the chance to plan an appropriate and meaningful summer program/camp for your child. Please answer all of the following questions. The more the staff knows about your child, the easier it will be for them to interact with and help your child have a fun, safe and memorable summer and the staff will be more equipped to serve the needs of your child. Please be as specific as possible.

1. What social, communication, or attitude skills would you like stressed this summer?
  
  
  
  
  
  
  
  
  
  
2. What kind of **physical/material reinforcement** (food, high-fives, time outs, rewards, etc.) do you use at home to increase appropriate behavior **and/or** to decrease negative behavior?
  
  
  
  
  
  
  
  
  
  
3. What kind of **verbal reinforcement** do you use at home to encourage appropriate behavior or to decrease negative behavior? Be specific on the wording.
  
  
  
  
  
  
  
  
  
  
4. What are your child's strength and weaknesses? Knowing this will help us capitalize your child's strengths and work on your child's weaknesses:
  
  
  
  
  
  
  
  
  
  
5. What situations (group, one on one, certain places, being put on the spot, asking or answering questions, etc....) are especially difficult for your child or produce anxiety and/or aggression?
  
  
  
  
  
  
  
  
  
  
6. What situations does your child respond well in or excel in?
  
  
  
  
  
  
  
  
  
  
7. Does your child use an alternative mode of communication such as a communication device, gestures, pictures, visual schedule, social stories or sign language? Please give us some important or common phrases, signs or uses:

**AUTHORIZATION & LIABILITY RELEASE**

In the event of an accident, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult supervisor to hospitalize and provide necessary treatment for my child/children, as named below. I acknowledge that the Grand Blanc Community Schools, the Grand Blanc Parks and Recreation Department and its' supervisors and chaperones cannot assume liability for injury incurred en route to or from day camp field trips and/or day camp activities.

I give consent for my child/children to take part in field trips or excursions under proper supervision.

I hereby authorize the use of pictures of my child for information or publicity relating to future programs.

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**WAIVER OF LIABILITY STATEMENT**

In registering my child/children for this activity, I hereby release the Grand Blanc Parks and Recreation Commission and all supervisors and leaders of all liability for damages or injuries sustained by my child while participating in these activities.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**NOTIFICATION OF MEDICATIONS IN CASE OF EMERGENCY  
AND/OR  
AUTHORIZATION TO ADMINISTER MEDICINE**

***Please Note: if your child is on medication for behavior during the school year, we ask that they continue on the same medication for the duration of summer camp. Please check next to the appropriate statement and sign.***

Camper's Name \_\_\_\_\_ Birth date \_\_\_\_\_

**My child will not need medication administered C.A.R.E. personnel during camp hours.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Authorization is hereby granted to C.A.R.E. personnel to administer or provide medication to the above student in accordance with the directives below.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Provide or administer medicine only from pharmaceutical labeled bottle bearing student's name and dosage limitations.**

1. Condition requiring medication \_\_\_\_\_

2. Name of medication \_\_\_\_\_

3. Dosage (amount) \_\_\_\_\_

4. To be given at what time(s)? \_\_\_\_\_

5. Directions for giving (with certain food/water?) \_\_\_\_\_

6. Comments regarding medication, including any other special directions for teacher observation, reporting, any difficulty taking medication or possible side effects: