Pennwood Adult Vacation Experience
June 19-23, 2017

2017 P.A.V.E. APPLICATION

I. GENERAL INFORMATION: (Please Print)

Name: _____Date of Birth:_____ Age: _____

Address: _____
(Street) (City) (State) (Zip

Home Phone:_____ Cell Phone_____

Email:_____

Emergency Contact : (Person familiar with camper, available from 10:00 AM - 3:00 PM)

_____ _____
(Name) (Telephone)

MH-IDD Supports Coordinator Name_____

COSTS AND FUNDING:

The Adult Camp Pennwood fee is $390.00, payable at the time of application. MH-IDD funding may Apply.

DEADLINES

Please complete and return all forms and payment by May 5, 2017.
(Application, Release Form, Health Exam Form, Medical History Form, Confidential Household Survey)

Send your application to:

Josh Leik
The Arc of York County
497 Hill Street
York, Pa 17403

- Please note that registrations will be accepted on a first-come, first-served basis and that the number of registrations may need to be limited.

II. INDIVIDUAL SKILLS DEVELOPMENT:

To help us provide you with the most enjoyable summer possible, please describe in detail the following information about your needs:

Toileting (assistance with clothes or toileting/Depends, constant supervision, independent, etc.)

Personal hygiene (washing hands, combing hair, menstrual care, etc.)

Dressing (buttons, zippers, putting clothes on, etc.)

Eating (physical assistance, utensils used, special diet, etc.)

Communications skills (non-verbal, sign language, language board, etc.)

Interactions with other adults (gets along well, fights, shy, etc.)

Behaviors (wanders off, easily upset, short attention span, etc.)

Aggressive behaviors and preventive techniques (hitting, biting, destroying property, etc.)

Activities: Sports, Arts and Crafts, Music (favorites, dislikes, needs, etc.)

Swimming skills (no experience, afraid of water, previous lessons, needs, etc.)

Allergies/Food Restrictions

Transfer Skills (if utilizing a wheelchair)

Did we miss anything? (Please include anything you think we should know.)

HEALTH EXAMINATION

BY LICENSED PHYSICIAN

Pennwood Adult Vacation Experience

I _____ authorize my physician to provide the following information. I understand that it will be used only by The Arc of York County's staff to help me during PAVE.

Signature: _____ Date: _____

All information is to be completed by a licensed physician.

Date of Exam: _____

Is the individual free of infectious disease? _____ YES _____ NO
If no, please indicate type of disease: _____

Medication(s) prescribed: _____
_____

Please list any medications that will need to be administered during P.A.V.E. (10 a.m.-3 p.m.)
_____
_____

Are there any medical reasons why this patient should not attend an outdoor day camp, including field trips?
_____

Identify any medical problems that may place this individual at an increased risk of medical emergency:
_____
_____

Circle one: In my opinion, this condition **does/does not** preclude his/her participation in an active camp/community activity.

Health History (Circle if applicant has had any of the following):

Asthma/Breathing Difficulties	Heart Disease	Convulsions/Seizures	Hepatitis
Bleeding/Clotting Disorder	Diabetes	Hypertension	Tuberculosis
		Other _____	

Allergies:

Hay Fever	Poison Ivy	Insect Stings	Food
Penicillin	Other Drugs		

Please explain if needed:
_____
Identify desired treatment if individual experiences acute allergic reaction to above allergies:
_____
_____

Past operations or serious injuries (please explain):

_____

_____

Disability or chronic or recurring illness:

_____

_____

The individual is currently under the care of a physician for the following conditions:

_____

_____

Instructions for management of individual's seizure disorder (if applicable):

_____

_____

Current treatment (include medications and dosages):

_____

_____

Please list any orthotics or prosthetics which may be necessary at camp. List any special instructions required to use them properly.

_____

_____

Describe any prescribed meal plan or dietary restrictions:

_____

_____

Date of last tetanus shot: _____

From completed by Dr. _____
(Please type or print)

Licensed Physician's signature: _____

Address: _____
(Street) (City) (State) (Zip)

Date form completed: _____

Date of most recent physical_____

RELEASE FORM

PARTICIPANT'S NAME: _____ DATE: _____

PHOTOGRAPHY CONSENT

I hereby grant permission for the staff of The Arc of York County or its designated representative to photograph me while participating in daily activities of P.A.V.E. These photographs may be used for publicity for The Arc of York County in its newsletter or annual calendar or in the newspaper or other media.

Signature: _____ Date: _____

TRANSPORTATION CONSENT

I hereby grant permission to be transported on field trips in a van provided by Kelly Transit during PAVE. If I need urgent medical care, I hereby grant permission to be transported to urgent care by an Arc staff member.

Signature: _____ Date: _____

LEGAL CONSENT

Absent gross negligence or wrongdoing by The Arc of York County, I hereby release The Arc of York County, the Board of Directors and its individual members, P.A.V.E., its staff, counselors, volunteers, and any and all persons who assist in taking charge of the program and activities from any and all liability or claim arising from the accidental injury to, or death of me, incurred during or in transit to or from my participation in programs and activities from any cause whatsoever.

I further waive claim on The Arc of York County for any loss or damage to my property, whether in the program or en route to and from the program.

Signature: _____ Date: _____

I have witnessed the signing of these releases.

Witness: _____ Date: _____

The Arc of York County

MEDICAL HISTORY FORM

P.A.V.E.

NAME: _____ BIRTH DATE: _____ AGE: _____

HOME PHONE: _____
ADDRESS: _____

EMERGENCY CONTACT:
NAME: _____ RELATIONSHIP: _____
HOME PHONE NUMBER: _____CELL #_____WORKPHONE #_____
ADDRESS: _____

PHYSICIAN'S NAME: _____ PHONE #: _____
DENTIST'S NAME: _____ PHONE #: _____

Do you have medical/hospital insurance? _____ If so, please indicate:

Carrier: _____ Policy or Group # _____
PA Medical Assistance Card (formerly ACCESS):
ID #: _____ PCS #PACs: _____

While attending P.A.V.E., I give permission to staff to use their own judgment in administering the following if needed:

_____ Tylenol_____ (indicate amount)
_____ Advil _____ (indicate amount)
_____ Benedryl _____ (indicate amount)
_____ Triple Antibiotic ointment
_____ Caladryl lotion
_____ Other _____ (indicate amount)

IMPORTANT -- THIS BOX MUST BE COMPLETED FOR ATTENDANCE

DAILY ADMINISTRATION OF MEDICATION/EMERGENCY AUTHORIZATION:

I give permission to personnel selected by the P.A.V.E. Coordinator to administer medication at my request and to apply routine first aid as needed.

If Arc staff determine that urgent/emergent care is needed in my best interests, I give permission for a physician to treat me, hospitalize me, and/or order appropriate diagnostic tests.

I certify that this health information, which I have supplied, is accurate and complete.

Print Name:_____

Signature: _____ Date: _____

Witness: _____ Date: _____

497 Hill Street
York, PA 17403
(717) 846-6589

THANK YOU FOR PARTICIPATING IN PROGRAMS OFFERED BY THE ARC OF YORK COUNTY.

1. We hope that you will be satisfied with your services. If, in spite of all our efforts, you are dissatisfied with some aspect of our services, please bring your dissatisfaction to the attention of the program manager or some other Arc manager. If your dissatisfaction is not resolved you may wish to proceed to a more formal method of complaint.

2. The Arc has a grievance policy -- which means that you can have your dissatisfaction can be recorded and submitted for a more formal review by the appropriate Arc manager.

   If you have a grievance, please ask for a grievance form or obtain one from The Arc's website (www.thearcofyorkcounty.org).

3. After submitting your grievance the appropriate Arc manager will respond to you within one week. If more time is needed to resolve the dissatisfaction, the Arc manager will call you to explain the delay and to tell you when to expect a decision. You will be kept informed.

4. If the outcome of The Arc's Grievance Procedure does not resolve your dissatisfaction, you can file a formal grievance with York-Adams MH/IDD, PA Office of Vocational Rehabilitation, or the organization which is funding your services.

THIS NOTICE WILL BE PROVIDED TO ALL PROGRAM PARTICIPANTS BY ARC DIRECT SERVICE PERSONNEL. IT IS TO BE EXPLAINED AND LEFT WITH THE PERSON(S) WHO WILL BE RECEIVING SERVICES OR THE GUARDIAN OR CARE-GIVER OF THE PERSON.

HOUSEHOLD SURVEY Summer 2017 PAVE

The Arc of York County receives contributions and funding from many sources, including United Way and the City of York/County of York. They have requested that we collect the following information. It is not mandatory for you to complete this form, but it will be appreciated as it will help The Arc receive much needed funding.

1. Please check the gender of the person(s) who will receive Arc services.
_____ Female _____ Male

2. Please check the age range of the person(s) who will receive Arc services.
0-5 _____ 6-8 _____ 9-14 _____ 15-18 _____ 19-21 _____ 22-61 _____ 62+ _____

3. Is the person who receives Arc services Hispanic/Latino?
_____ Yes _____ No

4. Please check which <u>one</u> racial description best fits the person who receives Arc Services: **<u>(Check one only)</u>**

Single Race		**OR**	**Multi-Race**	
White			Black or African American AND White	
Black or African American			Asian AND White	
Asian			American Indian or Alaska Native AND White	
American Indian or Alaska Native			American Indian or Alaska Native AND Black or African American	
Native Hawaiian or Other Pacific Islander			Other Multi-Race	

5. Please indicate the total number of persons currently residing in your household. _____

6. Please check which of the following describes your family's "head of household." (Check only one.)
_____ Male _____ Female _____ Two Parents

7. What is your total yearly family income from wages or salary, self-employment, social security, pension, public assistance, rent, interest, or other sources? (Check one line only.)

_____ $ 0---11,250
_____ $11,251---12,850
_____ $12,851---14,450
_____ $14,451---16,100
_____ $16,101---17,350
_____ $17,351---18,650
_____ $18,651---18,750
_____ $18,751---19,950
_____ $19,951---21,250
_____ $21,251---21,450
_____ $21,451---24,100
_____ $24,101---26,800
_____ $26,801---28,950
_____ $28,951---30,000
_____ $30,001---31,100
_____ $31,101---33,250
_____ $33,251---34,300
_____ $34,301---35,400
_____ $35,401---38,600
_____ $38,601---42,900
_____ $42,901---46,300
_____ $46,301---49,750
_____ $49,751---53,150
_____ $53,151---56,600
_____ 56,601 & over
_____ Unknown

8. Please list the places of employment for all members of your household. _____
_____

9. Name of Individual Receiving Services _____
Address _____
Signature of Person completing Form _____