



**Pennwood Adult Vacation Experience  
The Arc of York County  
June 18-22, 2018**

**2018 P.A.V.E. APPLICATION**

**I. GENERAL INFORMATION:** (Please Print)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

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

\_\_\_\_\_  
(Name) (Telephone)

**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 4, 2018.**

(Application, Release Form, Health Exam Form, Medical History Form, Confidential Household Survey)

**Send your application to:**

Alicia Zienkiewicz  
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  
FOR P.A.V.E.  
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 camp.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All information is to be completed by a licensed physician.**

I have examined the above applicant within the past twelve months.

Date of Exam: \_\_\_\_\_

Is the applicant 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 with field trips in the community?  
\_\_\_\_\_

Identify any medical problems that may place this applicant at an increased risk of medical emergency:  
\_\_\_\_\_  
\_\_\_\_\_

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
Penicillin	Other Drugs	

Please explain if needed:  
\_\_\_\_\_  
\_\_\_\_\_

Operation or serious injuries (please explain):

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Disability or chronic or recurring illness:

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

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

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Current treatment (include medications and dosages):

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

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Describe any prescribed meal plan or dietary restrictions:

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Identify any allergies or asthma and proper treatment if individual experiences acute condition:

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Date of last tetanus shot: \_\_\_\_\_

Form completed by Dr. \_\_\_\_\_

(Please type or print)

Licensed Physician's signature: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Date form completed: \_\_\_\_\_

**RELEASE FORM**

**CAMPER'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.

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:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**EMERGENCY CONTACT:**

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

**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)

\_\_\_\_\_ Benadryl \_\_\_\_\_ (indicate amount)

\_\_\_\_\_ Triple Antibiotic ointment

\_\_\_\_\_ Galadriel 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.

I give permission for a physician to hospitalize, order x-rays, routine tests, and/or secure proper Treatment for me.

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**The Arc of York County  
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 happy with your services. In spite of all our efforts, there may be a time that you do not agree or are unhappy with something about your services.
2. The Arc has a grievance policy -- which means that you can have your complaint reviewed by the appropriate Arc supervisor.
3. If you have a grievance, please ask for a grievance form. Assistance will be made available to complete the complaint process if needed.
4. When you have a formal complaint or grievance, it is The Arc's obligation to get back to you within one week. If more time is needed, The Arc supervisor is to call you to explain the delay and to tell you when to expect to hear from them.
5. If you are still unhappy and your complaint has not been resolved, you can file a grievance with MH/MR, OVR, or the organization which is funding your services.

**THIS NOTICE IS TO BE PROVIDED TO ALL PROGRAM PARTICIPANTS BY THE 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

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 one racial description best fits the person who receives Arc Services: **(Check one only)**

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

**Please complete this form and return it to The Arc at this address:**  
**PAVE**  
**The Arc of York County**  
**497 Hill Street**  
**York, PA 17403**

**This information will be kept strictly confidential. Thank you.**