CAMP PENNWOOD APPLICATION

2023

Ages 6-21 including 2023 Graduates

APPLICATION DEADLINE: April 21, 2023

Campers are responsible for payment of transportation via Kelly Transit. York-Adams MH/IDD does NOT pay for camper transportation. Payment for transportation is due prior to the first day of camp. Half is due by April 21st and the remainder is due by July 10th.

You may apply for a grant for transportation. The awarding of grants is based upon camper financial need and the amount of donations made to the grant fund in 2023. Grant applications must be submitted with the Camp Pennwood application. Grants are limited, and full funding is usually not provided.

TRANSPORTATION VIA KELLY TRANSIT IS NOT FREE.

2023 CAMP PENNWOOD APPLICATION

I. GENERAL INFORMATION: (Please Print)

Camper Name:_____

Date of Birth: _____ Age: _____

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

HomeTelephone #: _____

Father/Guardian: _____ Home Phone #: _____

Father's Address: _____

Father's Place of Employment: _____ Phone #: _____

Father's Email Address: _____

Mother/Guardian: _____ Home Phone #: _____

Mother's Address: _____

Mother's Place of Employment: _____ Phone #: _____

Mother's Email Address: _____

Emergency Contact (Must list person familiar with camper, other than parent, who is available from 9:30 AM –4:00 PM)

_____ _____
(Name) (Phone #)

Please list all persons your child may be released to. Campers will not be released to anyone except those persons listed here. (In custody situations, proof of custody may be necessary.)

_____ _____

_____ _____

MH/IDD Supports Coordinator (if applicable): _____

Current School: _____ Name of Teacher:_____

II. CAMP ATTENDANCE: Camp hours are 9:30 AM – 3:00 PM

■**CAMP BEGINS AT 9:30 AM. DO NOT DROP YOUR CHILD OFF AT CAMP BEFORE 9:30 AM.**

Request the desired weeks of attendance below. We will try to accommodate your requests, however, be advised that many age groups fill quickly and it may not be possible for your child to attend every requested week. You will be notified of your child's weeks at camp by mail. Camp will be in session the following weeks:

1. _____ July 10-14, 2023
2. _____ July 17-21, 2023
3. _____ July 24-28, 2023
4. _____ July 31-August 4, 2023
5. _____ August 7-11, 2023

Please place a check mark next to the week (s) that your child would like to attend camp:

III. COSTS AND FUNDING:

Payment for camp and half the transportation cost is due on April 21, 2023. If you need your child to use camp transportation at assigned pick-up points, the cost varies depending on how far your pick-up point is from camp. Please see page 5.

YOU MUST check one of the following:

1. Self Pay

_____ Please call The Arc for more information. **Payment for camp and ½ transportation cost is due by April 21, 2023.**

2. Person/Family-Directed Support Waiver or Consolidated Waiver

_____ I am paying for the cost of camp using my Person/Family-Directed Support Waiver or Consolidated Waiver funds as part of my Individual Service Plan. **I understand that I must pay ½ the transportation fee by April 21, 2023 if using camp transportation.**

3. Family-Driven Family Support Services

_____ I am paying for the cost of camp with my Family-Driven funding. **I understand that I must pay ½ the transportation fee by April 21, 2023 if using camp transportation.**

4. York-Adams Counties MH/IDD

_____ I am seeking payment from MH/IDD for my son/daughter to attend camp because he/she is not in a waiver or Family Driven Family Support Service. I am currently registered with the MH/IDD office. **I understand that I must pay ½ the transportation fee and for any additional weeks of camp that MH/IDD is not paying for by April 21, 2023.**

There may be an additional charge to you if your child requires medical treatment by a nurse at an off-site location and no other source of funding can be identified.

My Child's MH/IDD Supports Coordinator is _____.
My Child's MH/IDD (BSU) case number is _____.

Note: If your son/daughter is not registered with the MH/IDD office, please call the York office of MH/IDD (717-771-9618) or the Hanover office (717-632-0927) to apply for services.

DEADLINES

April 21, 2023 – Deadline for application submission.
April 21, 2023– Camp payment and half of transportation costs are due.
April 21, 2023 – Health Forms are due.

If you need extra time for Health Forms due to doctor appointments, it is very important to contact us at 717-846-6589.

July 10, 2023 – Remaining balance of transportation cost is due.

Late applications may result in your child not being able to attend camp unless there is an opening.

IV. INDIVIDUAL SKILLS DEVELOPMENT:

To help provide your son/daughter with the most enjoyable summer possible, please describe in detail the following information about your child's needs:

Toileting: (assistance with clothes or diapering, constant supervision, independent, etc.)

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

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

Eating: (physical assistance, only uses spoon, special diet, likes or dislikes, etc.)

Communication skills: (non-verbal, sign language, communication device, etc.)

Interactions with other children/adults: (gets along well, fights, is shy, gets upset by…, etc.)

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

Aggressive behaviors and tips for preventing behaviors: (hitting, biting, destroying property, what helps, etc.)

Does your child exhibit behavior at times that could result in injury to other campers or staff?

_____ YES _____ NO If yes, please describe on the back of this page.

Has your camper ever been accused of or charged with any criminal behavior, including theft, sexual or other assault, etc.?

_____ YES _____ NO

If yes, please explain:

_____
_____
_____
_____

Is your child receiving TSS services? _____ YES _____ NO

If so, give TSS Agency Name and Phone #:

_____

TSS Worker's Name:

_____

Behavior Specialist:

_____

Mobile Therapist: _____

Does your child use a wheelchair or other assisted mobility device? Which?

Transfer Skills: (if utilizing a wheelchair, what assistance is needed?)

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

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

Allergies/Food Restrictions:

Does your child require an aide or any special accommodations/ lift van while riding the bus during the school year? If yes, explain:

Did we miss anything? (Please include anything else you think we should know for the safety and enjoyment of your child and other campers.)

V. <u>TRANSPORTATION</u>:

If you want to use the bus pick-up system (Kelly Transit), the fees per week are as follows:

$95.00 – Zone 1 $100.00 – Zone 2 $105.00 – Zone 3 $110.00 – Zone 4

Half of the total transportation fee must be received by April 21, 2023. The remaining half must be received by July 10, 2023.

Please make checks payable to The Arc of York County.

_____ I will be providing transportation for the camper directly to and from camp.

_____ I am responsible for the required weekly fee to use the assigned pick-up bus system through Kelly Transit. I assure timely payment as required.

•_____ _____

PARENT'S SIGNATURE **DATE**

PLEASE CHECK WHICH PICK-UP POINT YOU WOULD LIKE TO USE:

Zone		**Location**
1	_____	Hannah Penn Middle School, 415 E. Boundary Avenue
1	_____	Edgar Fahs Smith Middle School, 701 Texas Avenue
1	_____	Jacob Devers Elementary School, 801 Chanceford Avenue
1	_____	Weis Market, 2850 Carlisle Road, Weiglestown
1	_____	Central York High School
1	_____	West York High School, Bannister Street, York
1	_____	First Church of Christian Scientist Reading Room, 1404 E. Market St, York
1	_____	Northeastern High School, Manchester
1	_____	York Suburban High School, 1800 Hollywood Drive, York
2	____	Kenny's Market, Spring Grove
2	_____	Dallastown High School (lot near football field)
2	_____	Holiday Inn Express, 140 Leader's Heights Road (lower lot)
2	_____	Kelly Transit, N. Main St, Dover
3	_____	Claire's Drive-In, Grandview and Blooming Grove Road, Hanover
4	_____	I would like a pick-up point in Dillsburg (The feasibility will be assessed by The Arc.)
4	_____	I would like a pick-up point in Shrewsbury (The feasibility will be assessed by The Arc.)

Please complete and return all of the following forms by April 21, 2023: Application, Release Form, Medical History Form, Payment Form, Household Survey (confidential), Health Exam.

Att: Camp Pennwood
The Arc of York County
497 Hill Street
York, PA 17403

APPLICATION DEADLINE IS April 21, 2023

The Arc of York County

Media Release Form

I hereby give my consent to all photographs, audio or video recordings taken of me or my minor child by The Arc of York County staff or their designee. I understand that any such photographs, audio and/or video recordings become the property of the The Arc of York County and may be used by the agency for educational, instructional, or promotional purposes determined by The Arc of York County in broadcast and electronic media formats now existing or in the future created.

____ Yes, I give my consent.

____ No, I do not give my consent.

Camper Name:_____
(please print)

Parent's/Guardian's Name: _____
(please print)

Parent/Guardian Signature:_____

Date: _____

HEALTH EXAMINATION
BY LICENSED PHYSICIAN
FOR CAMP PENNWOOD

2023

Child's name: _____ Date: _____

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

Signature: _____ Date: _____

TO BE COMPLETED BY THE DOCTOR

Campers must have been fully examined by a doctor between September 1, 2022, and May 31, 2023 to be able to attend camp.

I examined the above camp applicant on _____(date)

Is applicant free of infectious disease? Yes _____ No _____

If "No", please indicate type of disease: _____

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

Identify any medical problems which may place this applicant at an increased risk of medical emergency:
_____

In my opinion, the above individual's condition **does** / **does not** preclude his/her participation in an active camp program, including swimming and being exposed to domestic/farm animals. Explain if "does".

The applicant is under the care of a physician for the following conditions (Please include if applicant has diabetes or seizures, etc.): _____
_____
_____

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

Current medications/treatments: (include dosages): _____
_____
_____

Please list any medications that will need to be administered during camp (between 9:30 am and 3 pm):
_____
_____
_____

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

Describe prescribed meal plan or dietary restrictions:
_____
_____
_____

Describe any allergies: _____
_____
_____

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

Frequent Ear Infections	Heart Defect/Disease	Convulsions/Seizures
Diabetes	Bleeding/Clotting Disorders	Hypertension
Hepatitis	Spinal/Orthopedic Conditions	Asthma

Allergies:

Hay Fever _____	Insect Stings _____	Foods _____
Poison Ivy/Oak_____	Drugs _____	Other _____

Please explain managing above conditions, if needed:
_____
_____
_____
_____

Hx of operations or serious injuries (please note): _____
_____
_____

Disability or chronic recurring illness: _____
_____
_____

Please provide the following vaccination records:

Vaccines:	Dates given:
DPT/TD **Diphtheria** **Pertussis (Whooping Cough)** **Tetanus**	**1.** **2.** **3.** **4.** **5.** **6.**
TOPV Trivelent Oral Polio	**1.** **2.** **3.** **4.** **5.**
Measles	**1.** **2.**
Mumps	**1.** **2.**
Rubella (German measles, 3-day measles)	**1.** **2.**
HIB Haemophilus B	**1.** **2.** **3.** **4.** **5.**
Hep B Hepatitis B	**1.** **2.** **3.**
Other	

Note: TB/Mantoux test is no longer required.

Exam and form competed by Dr._____
(Please type or print)

Licensed Physician's signature: _____

Phone: _____

Address: _____
Street **City** **State** **Zip**

Date form completed: _____

CAMP PENNWOOD 2023
MEDICAL HISTORY FORM
THE ARC OF YORK COUNTY

CHILD'S NAME: _____
BIRTH DATE: _____ AGE: _____ SEX _____

PARENT/GUARDIAN:_____
HOME PHONE: _____ WORK PHONE: _____
ADDRESS: _____

PARENT/GUARDIAN:_____
HOME PHONE: _____ WORK PHONE: _____
ADDRESS: _____

EMERGENCY CONTACT:
NAME: _____ RELATIONSHIP: _____
TELEPHONE NUMBER: _____
ADDRESS: _____

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

Are there any restrictions to your child's physical activities at Camp due to a medical condition?
_____YES _____ NO
If YES, please give details about the restrictions: _____
_____
_____

Please list all medications and dosages that your child is taking:
_____
_____
_____

Is there anything else we should know about your child or are there any special instructions regarding your child's condition(s) (such as seizure or allergy management)?
_____
_____
_____

IMPORTANT: THE FOLLOWING INFORMATION MUST BE COMPLETED FOR ATTENDANCE
DAILY ADMINISTRATION OF MEDICATION/EMERGENCY AUTHORIZATION:
I give permission to personnel selected by the Camp 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
York County

HOUSEHOLD SURVEY

The Arc of York County receives contributions and funding from many sources, including the United Way and the 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.

Please check the gender of the person (s) who will receive services through The Arc of York County.
_____ Female _____Male _____Other

Please check the age range of the person (s) who will receive The Arc of York County services.
0-5 _____ 6-12 _____ 13-24 _____ 25-39 _____ 40-59 _____60+ _____

Please check the race or ethnic background of the person (s) who will receive The Arc of York County services
You may check more than one.

_____White (not Hispanic/Latino)
_____ African American/Black
_____ Latino/Hispanic Origin
_____ Other
_____ Asian
_____Hawaiian/Pacific Islander
_____ American Indian or Alaska Native
_____ Multi-race

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

_____ Unemployed
_____ Less than $15,000
_____ $ 15,000-$24,000
_____ $ 25,000-$49,999
_____ $50,000-$74,999
_____ Over $74,000

Please indicate your Zip Code. _____

Name of individual receiving services:_____
Address:_____

Signature of person completing form (not required)_____

Please complete this form and return it to The Arc at this address:
Dept _____
The Arc of York County
497 Hill St.
York, Pa. 17403

This information will be kept strictly confidential. Thank you.

The Arc of York County

Medical Needs Survey

Please feel free to offer any additional comments to the questions in this survey.
Participation in this survey is optional. It can be completed anonymously if preferred. By completing this form, you will be assisting The Arc of
York County staff to advocate for people with disabilities with regard to medical services including both general practice and specialties.

1. When seeking medical treatment/services is it important to you that the provider has experience treating people with intellectual/developmental disabilities.

2. Have you had difficulty in the past finding doctors who are comfortable serving individuals with intellectual and other disabilities.

3. If The Arc identified medical service providers who are experienced with and recommended for people with intellectual and other disabilities, would that information be useful to you?

4. Are you currently satisfied that your medical provider has a thorough understanding of your family member's disability and how to serve them?

5. Would it be important for you to have cooperating providers in one location?

Signature (optional)_____

Printed Name (optional)_____