

Elks Camp Grassick  
PO Box F  
Dawson, ND 58428  
701-327-4251

2 Week Camp Application

Date of Application: \_\_\_\_\_

## Permission

**I, as parent/guardian of this child, request that my child be admitted to Elks Camp Grassick for the Two Week Camping Session. I give permission for Elks Camp Grassick to obtain information from my child's school, teachers, therapists or other persons/organizations to help determine eligibility for this camping session. I understand that failure to provide honest and accurate information about my child could result in non-acceptance or early dismissal from Camp Grassick.**

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

## Identifying Information

Name of Child: \_\_\_\_\_ Gender:  Male  Female

Nickname or Preferred Name: \_\_\_\_\_

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

Name of Parent(s) or Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Place of Work: \_\_\_\_\_ Telephone: \_\_\_\_\_

Father's Place of Work: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency Contact: (must be someone other than parent or guardian)

Contact Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Agreement to Sponsor

### Sponsor/Parent/Guardian:

Elks Camp Grassick is a residential summer camp located in south central North Dakota. The camp is operated in the service of children with various disabilities and special needs. With your support, through this payment or sponsorship of this child, you are making it possible for some child/children to attend Elks Camp Grassick and receive the special services and programs that they may need and that will be very beneficial to them in their present day lives and in the future.

### Agreement:

I hereby agree to pay/donate \$ \_\_\_\_\_ to help pay for the child or children listed below to attend Elks Camp Grassick for the Two Week Camping session for children with Special Needs. My sponsorship fee will be paid to Elks Camp Grassick by October 1<sup>st</sup> of this camping year.

Name(s) of Child/Children: \_\_\_\_\_

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

Person or Organization Sponsoring: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

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

Parents or Guardians: If you are paying all of your child's camp fee or part of it, please fill in the spaces above. Camp fees may be paid in payments. If you have any questions, please feel free to call Camp Grassick at 701-327-4251.

### Referral Information

Name of School Child is Attending: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Child's Teacher: \_\_\_\_\_ Summer Telephone #: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_ Grade: \_\_\_\_\_

This Child is Referred to Camp Grassick by: \_\_\_\_\_

Title/Phone #: \_\_\_\_\_

This child could benefit from: (if more than one, please rank with number 1 being greatest need)

Speech/Language Therapy

Occupational Therapy

Remedial Reading

General Camping Experience

### General Information

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Occupation: \_\_\_\_\_

Child Lives with:  Mother  Father  Both  Guardian(s)  Other: \_\_\_\_\_

Number of siblings: \_\_\_\_\_ Number of children living in home: \_\_\_\_\_

Child's Diagnosis: \_\_\_\_\_

Activities of Daily Living:

Please give an evaluation of the child's ability in the area of daily living skills. (How independent is he/she?)

General Information Continued

Does this child use any of the following:

Glasses     Hearing Aids     Walker     Wheelchair     Orthotics

Does this child use any other type of adaptive equipment? \_\_\_\_\_ If yes, please explain:

Level of Supervision Needed for Each:

	Total Assist	Minimal Assist	Supervision	Independent
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does this child have bowel/bladder control? \_\_\_\_\_

Does he/she wear an incontinence product at any time? \_\_\_\_\_

Does this child have any special dietary needs? \_\_\_\_\_

Describe this child's swimming abilities: \_\_\_\_\_

Does he/she need to wear: lifejacket     earplugs

(All children will wear lifejackets on boats and in deep water)

## Social Study

1. Personal Traits: Please describe this child's maturity level, self-esteem and level of independence in the home environment.
2. Social Adjustment: How does this child get along in the home? (Relationship to parents, siblings?)
3. How does the child get along at school and with peers?
4. Discipline: Does this child exhibit any unusual discipline problems in his/her home environment? Yes No In school? Yes No In social settings? Yes No  
If yes, please explain.
5. Does this child have any repetitive behaviors, stims or tics? If yes, please describe.

Does this child have any behavior problems or physical outbursts? If yes, please answer the following questions.

- a. What sets off his or her behavior? Is there anything that escalates the behavior?
  - b. What does the behavior look like?
  - c. How long does a behavior typically last?
  - d. How often does the child exhibit these behaviors?
  - e. Is there anything that deescalates the behavior? What calms him or her down?
6. Are there any behavior plans or therapeutic practices that work with the child that we should continue at camp? If a behavior plan is in place, please attach.
7. Please list a few interests or hobbies of this child.
8. Is your child afraid of anything? Does your child have nightmares? Please describe. Is there anything that comforts him or her?
9. Has this child ever attended a summer camp before? Yes No  
 Has attended Elks Camp Grassick  Has attended \_\_\_\_\_  
If not, do you feel that this child could adjust to being away from home and in a camp environment?

Please attach any additional, pertinent information about this child.

## School Report

Please send this form to the appropriate school/teacher to complete. Return the completed form along with the rest of the application. This report is for Elks Camp Grassick use only.

### Identifying Information:

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_

Present School Attending: \_\_\_\_\_

Will child attend this school next year? \_\_\_\_\_ If no, where will they attend? \_\_\_\_\_

Name/Title of Person Completing School Report: \_\_\_\_\_

Address of School: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_ Grade: \_\_\_\_\_

Principal: \_\_\_\_\_ School's Telephone #: \_\_\_\_\_

Child's Teacher: \_\_\_\_\_ Home Telephone #: \_\_\_\_\_

Please define and describe this child's disability or special need:

Please give an appropriate comment on the characteristics listed below relating to this child.

1. Motivation: (For instance, what motivates child to complete work or change behavior?)
  
  
  
  
  
  
  
  
  
  
2. Is there a social curriculum that the child is receptive to? Is a reward system or consequence used?







### School Report Continued

12. Level of Supervision Needed for Each:

	Total Assist	Minimal Assist	Supervision	Independent
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How would you describe the student's general hygiene and grooming?

14. Is this child receiving any of the following special services in school or in the community?

Speech/Language Therapy  OT  PT  Remedial Reading  Counseling  Other

15. Is the child currently receiving professional attention for any special problems?

Yes  No If so, please describe or explain.

16. Does this child exhibit any special problems which you think need professional attention?

Yes  No If so, please describe or explain.

Please attach/include any additional, pertinent information about this child that camp staff should be aware of.

## Reading Report

To be completed if this child could benefit from remedial reading.

Please note: Although most children would benefit from some type of reading instruction while at Camp Grassick, only so many are selected to receive individual help in reading because of the number of instructors that we have available. Even if this child is not selected to receive individual reading instruction, they will still benefit from reading activities promoted within their cabin and cabin group.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_ Grade: \_\_\_\_\_

Present Reading Level (or BAS level): \_\_\_\_\_

Name of Reading Instructor: \_\_\_\_\_

If permissible, please include the reading instructor's summer telephone number. If for any reason our reading personnel would have specific questions during the summer, they could contact the child's teacher. Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Does this child receive special reading instruction or remedial reading?  Yes  No

If so, how many times a week? \_\_\_\_\_ For what length of time? \_\_\_\_\_

What is the present reading program or series being used with this child?

Reading Difficulties: Please check if the child is experiencing difficulties in any of these areas:

- Letter Recognition       Word Analysis Skills       Word Recognition  
 Comprehension       Oral Reading       Other \_\_\_\_\_

In your own words, please describe what you feel the child's reading problem is and what the child is working on to help him or her with this problem.

Please describe or give specific areas/skills you would like this child to work on over the summer if selected to receive individual reading instructions while at camp.

## Speech and Language Report

To be completed if the child is receiving or could benefit from speech therapy.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Child's Speech Language Pathologist: \_\_\_\_\_

School System: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

If permissible, please include the speech therapist's summer telephone number. If for any reason our speech/language personnel would have specific questions during the summer, they could contact the child's school clinician.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **Speech/Language Information:**

Is this child presently receiving speech/language services?  Yes  No

If so, how many times per week: \_\_\_\_\_ Length of time per session: \_\_\_\_\_

Speech Problems Include:  Minor Articulation  Major Articulation  Language

Cleft Palate  Fluency  Hearing Loss  Cerebral Palsy  Down Syndrome

Pragmatics/Social Language  Other: \_\_\_\_\_

Does this child wear hearing aids?  Yes  No Is this child  Verbal  Non Verbal

This child's speech is:  intelligible  barely intelligible  unintelligible

Does this child use a communication device:  Yes  No If so, what \_\_\_\_\_

In your own words, please describe what you feel the speech and/or language problem is.

## Speech and Language Report Continued

What materials, programs, special equipment, etc. are being used with this child?

Please give a brief description of therapy the child is presently receiving and concerns being addressed in the school therapy setting.

Please give some suggestions or specific areas of concentration you would like our speech/language personnel to work on with this child while at camp. (Please keep in mind the number of weeks this child will be at camp.)

Please Note: To best utilize the weeks we have with the children and in order for our speech/language personnel to continue to follow up on what the school therapist is working on with this child, we would appreciate any information or materials concerning the following included with this speech/language report: Current IEPs if applicable, most recent test results, therapy objectives and goals and possibly a brief description of therapy the child has been receiving. If the child is nonverbal, what materials, programs, or type of communication approach is being used? Thank you.

## Occupational Therapy Report

To be completed if the child is receiving or could benefit from occupational therapy.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of Classroom: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Child's Occupational Therapist: \_\_\_\_\_

School System: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

If permissible, please include the occupational therapist's summer telephone number. If for any reason our occupational therapy personnel would have specific questions during the summer, they could contact the child's school clinician.

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **Occupational Therapy Information:**

How does this child ambulate?  Independently  Crutches  Walker  Wheelchair

If the child uses a wheelchair, how independent is he/she in ADLs, transfers, mobility, etc.

Does this child wear orthotic devices?  Yes  No If so, what type? \_\_\_\_\_

full time  part time  night

Has this child ever been evaluated for Occupational Therapy?  Yes  No

Is the child presently receiving Occupational Therapy?  Yes  No

If so, how many times per week? \_\_\_\_\_ Length of time per session \_\_\_\_\_

What areas and/or concerns are being addressed? Please give a brief description of therapy the child is presently receiving.

### Occupational Therapy Report Continued

Please indicate specific areas of concentration you would like addressed or certain skills you would like us to work on while this child is attending camp.

Please include/attach any other information that you think would be helpful to our OT staff while working with this child.

### Physical Therapy Information

Is this child presently receiving Physical Therapy?  Yes  No

If so, how many times a week? \_\_\_\_\_ For what length of time? \_\_\_\_\_

What is his/her diagnosis? \_\_\_\_\_

Name of child's Physical therapist \_\_\_\_\_

Work phone number: \_\_\_\_\_

**Please Note:** Please include the most recent Occupational and Physical therapy evaluation and reports concerning this child. Information concerning materials and/or programs being used with this child will be very helpful. Also areas/concerns being addressed with this child would be helpful to know about. If there is any indication of tactile defensiveness with this child, please let us know.

### Medical Report

Name of Child: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Clinic where Physician Works: \_\_\_\_\_ Phone#: \_\_\_\_\_

Family's Insurance Company: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Medical Assistance # (If Applicable): \_\_\_\_\_

Are Immunizations up to date:  Yes  No Date Issued (If Available): \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Drug/Medication Allergies: \_\_\_\_\_

Seasonal/Environmental Allergies: \_\_\_\_\_

Primary Medical Diagnosis: \_\_\_\_\_

Secondary Medical Diagnosis: \_\_\_\_\_

Health History: (Give Approximate Age of Child when illness occurred)

- |                        |                            |                                   |
|------------------------|----------------------------|-----------------------------------|
| _____ Asthma           | _____ Bedwetting           | _____ Bleeding/Clotting Disorders |
| _____ Chicken Pox      | _____ Diabetes             | _____ Encephalitis                |
| _____ Epilepsy         | _____ Fainting             | _____ Frequent Ear Infections     |
| _____ Hearing Problems | _____ Heart Defect/Disease | _____ Hypertension                |
| _____ Incontinence     | _____ Measles              | _____ Mononucleosis               |
| _____ Mumps            | _____ Nightmares           | _____ Pneumonia                   |
| _____ Seizure Disorder | _____ Sinus                | _____ Sleepwalking                |

Please elaborate on any of the checked boxes if necessary:



### Medical Report Continued

Does this child have any history of seizures?  Yes  No Are they controlled?  Yes  No

What kind or type, etc? \_\_\_\_\_

Is this child's physical activity to be restricted for any reason?  Yes  No

If yes, please explain: \_\_\_\_\_

**Please attach a list of medications this child will be taking while at Camp Grassick:**

**NOTE: Please bring the child's medication to camp in their original containers with legible prescription labels.**

Please check any medications this child may take if needed while at Camp Grassick:

- Tylenol/Acetaminophen     Advil/Ibuprofen     Benadryl     Allergy medicine  
 Cough Drops     Cough/Cold medicine     Pepto Bismol     Any of the Above

Is there any OTC medicine that this child should **NOT** take? \_\_\_\_\_

Any other specific concerns or pertinent information concerning this child's health that the staff of Elks Camp Grassick should be aware of?

**Please Note:** All children accepted for attendance at Elks Camp Grassick must receive a physical examination by a doctor before coming to camp. The "Report of Physical Examination" form should be filled out completely by a physician and sent to camp prior to the child's arrival at camp. Attachment of the physical examination report would be very beneficial during the screening and selection process, but if the cost of such a physical examination is a concern, this form does not have to be filled out until after you know that this child has been accepted.

Report of Physical Examination for Elks Camp Grassick

To be completed by a Physician

Name of Child: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Temperature \_\_\_\_\_ Lungs \_\_\_\_\_ Pulse \_\_\_\_\_ Eyes \_\_\_\_\_

Nose \_\_\_\_\_ Throat \_\_\_\_\_ Tonsils \_\_\_\_\_ Ears \_\_\_\_\_

Skin \_\_\_\_\_ Heart \_\_\_\_\_ Hernia \_\_\_\_\_ Feet \_\_\_\_\_

Genitals \_\_\_\_\_ Nits/Lice \_\_\_\_\_

Other Concerns:

Describe any abnormal findings:

Has this child recently had a surgery or major illness?  Yes  No

If yes, please explain.

Are all immunizations up to date?  Yes  No

Should this child's physical activity be restricted in any way?  Yes  No

If yes, please explain:

Does this child have any history of seizures?  Yes  No If yes, what type? \_\_\_\_\_

If yes, are they controlled?  Yes  No Medication for seizures? \_\_\_\_\_

Report of Physical Examination for Elks Camp Grassick Continued

Please describe any restrictions or specific concerns:

Any other pertinent information concerning this child's health that we should be aware of:

Please inform us of any medication which will be taken by this child during his/her stay at Elks Camp Grassick. (This camp employs a camp nurse during the summer.) Please attach a list of medication if necessary:

I have examined \_\_\_\_\_ and find him/her free of communicable diseases, free of nits and lice, and fit to attend Elks Camp Grassick if he/she is accepted.

Physician's Name: \_\_\_\_\_ (print)

Clinic: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_