

Dear Parents, Caregivers and Variety Club Campers,

Enclosed please find the information needed to get the ball rolling to attend Variety Club Camp Weekend Retreats in 2011-2012! **PLEASE TAKE A MOMENT TO READ ALL INFORMATION CAREFULLY AS SOME THINGS ABOUT OUR WEEKEND RETREAT PROGRAM HAS CHANGED!** If you attended our Day or Overnight Camp in the Summer of 2011 you only need to fill out the first page of the application and make sure the physical we have on file is within one year of the sessions your child plans to attend! **If there have been any medication changes please make sure we have written notification from the doctor.**

CAMP DEPOSIT

Our Weekend Retreats cost \$275 per session and we require a non-refundable deposit of \$100 for each session you are signing up for in order to reserve your spot. If an agency is paying, we will require in writing, from an authorized representative of the agency, that the agency will pay in full for services rendered. In addition, we have a scholarship program for families who qualify. We are also willing to set up payment plans so that your child can enjoy Variety Club Camp! Please read the last page of the application for further details. If you have any questions in regards to this please do not hesitate to call us at (610)584-4366.

WEEKEND RETREAT

We are offering seven weekend camping sessions beginning Friday, September 16, 2011. The weekend sessions begin on a Friday evenings at 7pm and run through Sunday morning at 10a.m! Weekend Retreat Camp tuition is \$275 per weekend. Please see application for definite dates.

Here are some highlights of the Weekend Retreat 2011 - 2012 program:

- ❑ All sessions will include campers with special needs ages 7-21 years – campers ages 18-21 need to be enrolled in an educational program in a public or parochial school system to be eligible for Camp. Campers are grouped in cabins according to age and functioning level, and programs are also geared to the ability of the individual camper. Each session will have a maximum of 35 campers, and a 1:3 staff ratio will be in place. Some campers will require a 1:2 staff ratio that may be arranged at Variety Club Camp! If your camper requires one to one care, please contact the Director, Meredith Vivaldi, at the Camp offices to discuss this need. An additional fee may need to be added to your Camp tuition to support the care of your camper. Most of our campers can work in a 1:2 staff ratio setting. Contact Meredith with questions!
- ❑ All campers are welcome to attend all Weekend Retreats regardless of disability!

While we have made some changes to our Weekend Retreat program, for those returning and new campers, what hasn't changed is our commitment to having a fun, safe and action packed program! Many of you will experience Variety Club Camp as you have in the past, reconnecting with old friends and seeing the counselors! The first-time campers can look forward to making new friends and having the time of their life participating in camp programs including golf, tennis, drama, music, arts and crafts, nature and more! Bring it on!

First time campers will have an interview prior to the Weekend Retreat with the Camp Director and one of the Nursing staff which will also assist us - and you - in getting to know our Camp and choosing one of our programs.

If you have questions about which session your child would best fit in to, or any questions in general, please contact Overnight Camp Director Meredith Vivaldi at 610-584-4366 ext 1029 or via e-mail at mvivaldi@varietyphila.org.

ANY OTHER QUESTIONS?

Please feel free to contact our Camp office at 610-584-4366. Check out our website at www.varietyphila.org for more information, and a virtual tour of the facility.

We look forward to seeing you in Summer 2011!

Sincerely,

Angus Murray
Managing Director



2011 – 2012 Weekend Retreats APPLICATION FOR ADMISSION

Please check appropriate box(s) below: \$275 Per Weekend



- September 16-18, 2011
- October 21-23, 2011
- November 18-20, 2011
- December 9-11, 2011
- February 24-26, 2012
- March 23-25, 2012
- April 27-29, 2012

Date of Application: _____

Child Information *****

Child's Name: _____ DOB: _____ AGE: _____
(Last) (First)

Address: _____
Street City State Zip

Diagnosis: _____ Home Phone: _____ Child's Gender: M / F

Parent's Names: Mother _____ Father _____

Child Lives with: Mother/ Father / Grandparent / Foster Parent/ Other _____

Alternate Phone (work or cell): _____ (name)
Contact name: _____

Email Address: _____

Has child attended Variety Club Camp before? Yes No If yes, what years and program? _____

Who Is Paying For Camp *****

Check One: Private/Family Agency School District Scholarship Other

Name: _____ Organization _____ Phone Number: _____

Address: _____
Street City State Zip

Medical/ Health Information: (Complete carefully; does not require a physician's signature)

Does your child have any of the following? (please check those that apply)

YES NO

- History of seizures If YES: Type: _____ Duration: _____ Date of last one: _____
- Shunt If YES: Date of last revision: _____

Does your child have any allergies? (please check those that apply)

YES NO

- Medications If YES, which ones? _____
- Foods If YES, which ones? _____
- Insect bites If YES, how do you treat reactions? _____
- Pollen/ outdoors If YES, how do you treat reactions? _____

Hygiene / Toileting Routines: (please indicate those that apply to your child)

YES NO

- Has Bladder control
- Has Bowel control
- Has accidents If YES, when are they typically? _____
- Wears diapers If YES, when? daytime bedtime
- Requires Catheterization If YES, please complete:
 Independent Dependent Type: _____ Size: _____
- History of Bladder Infections If YES, list treatment _____
- History of Bed wetting? If YES, please indicate frequency: _____
- Bowel Program? IF YES, please explain: _____
- Bladder Program? If YES, please explain: _____

Self-Care: (please indicate those that apply to your child)

- Able to dress self If NO, please complete:
 Needs supervision only Requires assistance with dressing Dependent
Adaptations required? _____
- Able to shower self If NO, please complete:
 Needs supervision only Requires assistance with washing Dependent
- Able to complete personal hygiene If NO, please complete:
 Needs supervision only Requires assistance with washing Dependent for showers

Feeding: (please indicate those that apply to your child)

YES NO

- Able to feed self If NO, please complete:
 Needs supervision only Requires assistance with cutting Dependent
Adaptations required? _____
- Has a feeding tube If YES, please complete:
Type: _____ Feeding Schedule: _____
Type of food for tube feeds: _____
- Dietary Restrictions ? If YES, list restrictions: _____

Communication: (please indicate those that apply to your child)**YES NO** Visual Impairment If YES, does child wear corrective lenses? yes no Hearing Impairment If YES, is a hearing aide used? yes no Communicates verbally Communicates with adaptations

If YES, please indicate which form of communication is used:

 sign language Communication Device (list type) _____ PECs (picture exchange system) Other _____ Communicates wants and needs independently with identified system of communication**Behavior:****YES NO** Interacts appropriately with peers

If NO, please explain: _____

 Has behavioral challenges

If YES, please explain: _____

Behavioral Management Techniques: _____

 Does your child have a TSS or wrap around throughout the year?**Mobility****YES NO** Activity Restrictions If YES, please list: _____ Ambulatory Wheelchair userIf YES, indicate type: manual power Description: _____ Wears orthoticsIf YES, indicate type: shoe inserts MAFOs DAFOs Other: _____ Uses crutches Uses a walker***Application is for screening purposes only; if accepted to program, child will receive a full acceptance package.****Policies & Fee Information****Deposit:** All camp applications must include a **non-refundable \$100** check, money order or credit card number for each session, in order to secure your space at camp. The deposit will be applied to the session fee.**Due Dates:** Session fees must be paid in full prior to camp attendance (no exceptions).

Payments are welcome.

One-to-One Option: we will offer a limited number of one-to-one attendants throughout the summer at an additional cost. (Weekend Retreats - \$137.50) One-to-one assignments will be made on a first come, first serve basis.**Financial Assistance:** In order to be considered for financial assistance, applicants must submit a W2 and fill out the appropriate form. Please contact the camp to have a form sent to you. A minimum \$25.00.00 co-pay will be required of all financial aid recipients. Financial aid will be awarded based on need and available funds. First consideration will be given to applications received by Sept. 9th, 2011.**Refunds:** The camp deposit is non-refundable, no exceptions.**Cancellations:** Program fees (minus \$100 deposit) will be refunded if a camper cancels with a minimum 60-day notice; refunds for cancellations of less than a 60-day notice will be considered upon request on a case-by-case basis.

By signing below I pledge that I have filled out the above information honestly and to the best of my ability. Signing below also signifies that I have read and understand the policies and fee information stated above.

Parent of Guardian_____
Date

2011 - 2012 De-Escalation Form



Camper's Name: _____

Please fill out the following sections of this form. By filling each section out, it will help our staff better understand your child. Thank you.

Triggers: *What makes your child upset, angry, anxious, and/or overwhelmed?*

- | | |
|---|---|
| <input type="checkbox"/> Being Touched | <input type="checkbox"/> Being forced to do something |
| <input type="checkbox"/> Encroachment of personal Space | <input type="checkbox"/> Physical Force |
| <input type="checkbox"/> Yelling | <input type="checkbox"/> Being isolated |
| <input type="checkbox"/> Loud Noises | <input type="checkbox"/> Some lying to them |
| <input type="checkbox"/> Contact with person who is upsetting | <input type="checkbox"/> Being threatened |
| <input type="checkbox"/> Called names or made fun of | <input type="checkbox"/> Other: _____ |

Warning Signs: *What are some warning signs your child exhibits when frustrated or in distress?*

- | | |
|--|---|
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Throwing Objects |
| <input type="checkbox"/> Not taking care of self | <input type="checkbox"/> Crying |
| <input type="checkbox"/> Yelling | <input type="checkbox"/> Running |
| <input type="checkbox"/> Swearing | <input type="checkbox"/> Hurting others |
| <input type="checkbox"/> Pacing | <input type="checkbox"/> Not Eating |
| <input type="checkbox"/> Being Rude | <input type="checkbox"/> Not Talking |
| <input type="checkbox"/> Clenching Teeth | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Breathing Hard | |
| <input type="checkbox"/> Clenching Fists | |

Calming Strategies: *What is helpful for your child to calm down?*

- | | |
|--|--|
| <input type="checkbox"/> Listen to music | <input type="checkbox"/> Pacing the halls |
| <input type="checkbox"/> Reading a book | <input type="checkbox"/> Having a drink of water |
| <input type="checkbox"/> Wrapping in a blanket | <input type="checkbox"/> Dark room (dimmed lights) |
| <input type="checkbox"/> Writing a journal | <input type="checkbox"/> Hugging a stuffed animal |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Doing artwork |
| <input type="checkbox"/> Talking to staff | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Talking with peers | |
| <input type="checkbox"/> Calling a family member | |
| <input type="checkbox"/> Time alone | |
| <input type="checkbox"/> Going for a walk with staff | |

Please use the back of this form for any additional information that you feel may be important.



Variety Club Camp and Developmental Center
 2950 Potshop Road, P.O. Box 609, Worcester, PA 19490
 Phone: (610)584-4366 Fax: (610)584-5586

Notes from the Health Center for Weekend Retreats 2011-2012.....

Just a reminder to all parents regarding medications, health forms, etc.....

No child will be allowed to attend camp/programs without having the Health History/Examination Form complete and on file. There will be NO exceptions. Health forms are acceptable for one year from the date of the doctors' signature. If you are unsure of the date of your child's last physical, than please feel free to contact me.

When sending your child to camp/programs, please make sure I have the most recent medication orders on file. If there is a change in your child's medication, please make a copy of the prescription before you get it filled. You can then mail it to me. We cannot administer a medication without a doctors' written order. Medication **must** be in its original bottle. The directions on the bottle must coincide with the orders on the Health History/Examination form and/or the prescription. This includes prescription medications, vitamins, supplements, tube feeds, and over the counter medications. Please keep over the counter medications in their original packaging.

Please only send enough medication for your child's stay at camp **plus one extra dose.**

All Weekend Retreat campers must check in with the nurse...even if they receive no medication!!!

Please note: **For Weekend Retreats...**Medications will not be administered by VCC nurses on Friday nights, unless the medication is a sleep aid. Medications that need to be given Friday night must be given by the parent or guardian. Please make arrangements with me if this is a problem.

Physician Signature and Parent signatures are required on Health History/Examination Form. The forms are invalid if there are not signatures in the designated areas.

During the off-season I am in the office one day a week, that day varies. If you do not reach me in the office than please call me on my cell phone with any questions or concerns that you may have.

I look forward to seeing your children and I hope everyone is staying healthy.

Kelly Leshner R.N.
 Nurse Manager

Office 610.584.6279
 Cell Phone 610.653.6456

DIRECTIONS FOR COMPLETION:

1. Have Physician complete and sign
2. Mail or Fax to *Variety*;
P.O. Box 609;
Worcester, PA 19490
Fax: (610)584-5586
3. Must be completed *every 12 months* while enrolled in Variety programs.

Health History/ Examination Form 2011



Date of Application: _____

Child Information

Child's Name: _____ DOB: _____ AGE: _____ Child's Gender: M / F
(Last) (First)

Address: _____
Street City State Zip

Diagnosis: _____ Home Phone: _____

E-Mail: _____

Parent/ Caregiver Information

| Caregiver Name | Relationship to Child | Address | Phone Numbers |
|----------------|-----------------------|---------|---------------|
| 1. | | | Work: |
| | | | Cell: |
| 2. | | | Work: |
| | | | Cell: |

Emergency Contact Information

if unavailable in an emergency, please list people that VCC can notify:

| Name | Relationship to Child | Address | Phone Numbers |
|------|-----------------------|---------|---------------|
| | | | |
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Insurance Information

YES NO

- Is the participant covered by family medical/ health insurance?
If so, List Carrier: _____ Group # _____

PARENTS, PLEASE SIGN LAST PAGE OF FORM!

THE INFORMATION BELOW MUST BE COMPLETED BY A PHYSICIAN

Baseline Vital Signs

Temp: _____ Pulse: _____ Respirations: _____ Blood Pressure: _____ Height: _____ Weight: _____

Health History

Please list any injury, illness, or infectious diseases within the last 6 months: _____

Please indicate any chronic or reoccurring illness or conditions: _____

Please indicate any hospitalizations and/or surgeries and dates occurred: _____

Allergies

YES NO

- Medications If YES, which ones? _____
 Foods If YES, which ones? _____
 Insect bites If YES, how are reactions treated? _____

Pollen/ outdoors If YES, are reactions treated? _____

Immunizations:

Which of the following has the child had?

Measles Chicken Pox German Measles Mumps Hepatitis B Hepatitis C

PDD: Date of last test: _____ Results? Positive Negative

If negative, Date of last chest x-ray: _____ Results? Positive Negative

Please list immunization dates for the following:

| Vaccine | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|-------------|-------|-------|-------|-------|-------|-------|
| DTP | | | | | | |
| TD | | | | | | |
| Tetanus | | | | | | |
| Polio | | | | | | |
| MMR | | | | | | |
| Or Measles | | | | | | |
| Or Mumps | | | | | | |
| Or Rubella | | | | | | |
| Influenza B | | | | | | |
| Hepatitis B | | | | | | |
| Varicella | | | | | | |
| Pneumonia | | | | | | |

Electronical print of immunization record is acceptable.

Physical Assessment ('WNL's' represents within normal limits)

Psycho/Social System

WNL'S

Any history of mental illness? _____

Currently in treatment for mental illness? _____

Comments _____

Cardio-Vascular System

WNL'S

Any history of high blood pressure? _____

History of angina? _____

Comments _____

Respiratory System

WNL's

History of Asthma? _____

Comments _____

Neurological System

WNL's

History of seizures? _____

Shunt in place? _____

Comments _____

Skeletal System

WNL's

History of joint pain? _____

Uses prosthesis? If so, what kind? _____

Activity restrictions?, Uses wheelchair?, crutches?, walker? _____

Uses orthotics? _____

Comments _____

Muscular System

WNL's

History of muscular pain? _____

Contractures? _____

Comments _____

Integumentary System

WNL's

Any rashes? _____

Comments _____

Endocrine System

WNL's

History of Diabetes? _____

GI System

WNL's

Feeding Tube? If so, provide orders _____

Comments _____

GU System

WNL's

Independent or dependent bathroom skills? (circle one) _____

Bladder training program? _____

Incontinent or continent? (circle one) _____

Catheterization? _____ if so, provide orders. _____

Comments _____

Reproductive system

WNL's

Date of last menses? (if applicable) _____

Comments _____

Medications *(Please include prescription, over-the-counter, and non-prescription drugs taken routinely)* *****

- This Child takes **NO** medications on a routine basis
- This Child takes medications as follows:

| Medication (Type / Name) | Dosage (mg/ ml) | How Administered (mouth/ feeding tube/ crushed/ applesauce) | Frequency (# /day) | Times (AM/ Lunch/PM/ Bed) |
|-----------------------------|--------------------|--|-----------------------|------------------------------|
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- Please attach any additional pages as needed; endorse each with physician signature.

Comments

Over-Counter Medication

This is a list of over-counter medications that will be available to your child while participating in Variety Club Camp and Developmental Center programs. Please complete the information requested.

My child, (full name) _____, may have the following medication(s) as needed, while at camp. Medication will be given as directed on the label, unless otherwise instructed by physician.

(Please circle one)

| | | |
|------------------|-----|----|
| Tylenol* | Yes | No |
| Cough Medication | Yes | No |
| Cold Medication | Yes | No |
| Ibuprofen* | Yes | No |
| Laxative | Yes | No |
| Antacid* | Yes | No |
| Anti-diarrhea | Yes | No |
| Benadryl | Yes | No |

* Indicates medication that is most often required

Please list any allergies: _____

Physician Signature: _____ **Date:** _____

Physician Address: _____

Physician Phone #: _____ **Fax:** _____

Parent/ Caregiver Signature: _____ **Date:** _____

All areas must be completed. If it does not pertain to your child, indicate with 'N/A' (non-applicable)