

Participant First & Last Name	ESY: Y/ N
Transportation: Parent Drop off / School Bus	OT: Y/N
School District:	SLP: Y/N
Grade: Age:	1:1 : Y/N

A photo of each applicant is required and can be emailed to ebloyd@newavenues.net or hardcopies given directly to Emily Bloyd, Program Director.

Participant Name _____ *Age* _____

NEW AVENUES TO INDEPENDENCE



**New Avenues Summer Camp
2024 Registration Packet**

June 24- July 25, 2024

Emily Bloyd

Children's Programs Director

Cell: (216) 390-2617

ebloyd@newavenues.net

New Avenues Summer Camp is held at Broadmoor School
8090 Broadmoor Rd. in Mentor | 9:00 am-2:00 pm | Monday-Thursday

Application Deadline: Wednesday, May 22nd
Please submit electronically to ebloyd@newavenues.net or to directly to
Broadmoor School, 8090 Broadmoor Rd, Mentor, OH

Participant Name:

Summer 2024

All important information relative to the participant's health and well-being should be on the application. Please DO NOT rely on verbal instructions at the time of registration to communicate important information about your child.

Participant Information

Participant Name: _____ Nickname: _____ Gender: Male Female

DOB: _____ Age: _____ Disability (Please describe): _____

Camper T-shirt Size: **Child:** S M L XL **Adult:** S M L XL 2XL 3XL 4XL

Mailing Address: _____
Street City/State Zip

Name of Legal Guardian: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

What is your preferred method of receiving notifications and paperwork: Email Postal Mail

Emergency Contact Information

Emergency Contact #1 Information: Parent(s) Guardian Caregiver Other: _____

Name: _____

Address: _____
Street City/State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact #2 Information: Parent(s) Guardian Caregiver Other: _____

Name: _____

Address: _____
Street City/State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Health History

Age: _____ Weight/lbs.: _____ Height: _____

REQUIRED: Primary Diagnosis (medical, no abbreviations): _____

Secondary Diagnosis (if any): _____

Other conditions or concerns (including psychiatric): _____

Allergies:

Medication: _____

Food: _____

Environment/Animals: _____

Comments/Allergy Reactions: _____

Seizure Disorders: Does Not Apply Tonic-Clonic (Grand Mal) Non-convulsive (Petit Mal) Psychomotor Nocturnal Mixed

Typical Seizure Frequency: _____ Typical Length of Seizure: _____

Known Triggers, PRN Medications (if any), and protocol to follow: _____

Does the participant have a history of:	Yes	No	Does the participant have a history of:	Yes	No
Asthma			Frequent Ear Infections		
Frequent Colds			Stomach Disorders		
Heart Disorder/Disease			Urinary Tract Disorders		
Episodes of Passing Out			Diarrhea		
Bleeding Disorders			Constipation		
Hepatitis A, B, or C			Problems with Joints		
Diabetes			Chronic or Recurrent Illnesses		
Skin Problems (rashes, itching)			Past or Recent Surgeries		
Skin Breakdown (bedsores)			Past or Recent Hospitalization		
Eating Disorder/Difficulty Swallowing			Problems Sleeping		
Emotional Difficulty (For which professional help has been sought)			Adaptive Equipment (braces, wheelchair, walker, hearing aid, C-PAP)		
Head Injury			Signs/symptoms of communicable disease		
Frequent Headaches			Other:		

Please explain "yes" answers from above

-

Participant Name: _____

Summer 2024

Insurance Information

Name of Health Insurance Company: _____ Group Number: _____

Policy Holder: _____ Policy Holder ID: _____

Primary Care Physician: _____ Phone Number: _____

Primary Dentist: _____ Phone Number: _____

Preferred Hospital: _____

Mobility and Special Appliances

Indicate all that apply to camper:

- Walks/Runs Independently
- Uses Walker/Crutches/Cane
- Uses Wheelchair: Manual Power
- Wears AFOs or Braces
- Prosthesis
- When:** For Long Distances At All Times
- Who Maneuvers:** Self Others

Mobility Comments: _____

Communication

- Uses complete sentences
- Understands complete sentences _____
- Understands 2-3 word phrases _____
- Uses single words
- Understands single words _____
- Uses sign language
- Understands sign language _____
- Uses/understands gestures, points, etc. _____
- Uses pictures or word cards _____
- Uses adaptive systems such as a communication board _____
- Writes to communicate
- Able to read _____
- Facilitated communication (devices used; who usually acts as a facilitator?) _____

Mealtime/Snacks

Food Likes: _____

Food Dislikes: _____

Typical appetite is: Large Typical Small

Participant can use: Fork Spoon Knife Uses special utensils (please label and bring)

Takes portions independently Needs Food Cut Drinks from Cup Uses Straw

Diet: Standard Chopped Blended/Pureed Low Salt Low Calorie Low/No Sugar

Uses G-Tube Other

G-Tube information (Camper families furnish all supplies needed for the 5 weeks of camp.):

Formula Type	Amount	Time	Infusion type (bolus/pump)

Toileting

Please bring all supplies (briefs, wipes, swimming briefs, etc.) for the **duration** of camp.

- Uses toilet independently Needs to be reminded _____
 Needs some assistance using the toilet

- Uses the toilet on a schedule (Please list schedule) _____
 Does not use toilet at all (uses incontinent briefs, etc.) _____
 Is independent in menstrual care (if applicable)

How does he/she let you know the need to go to the restroom? _____

Dressing

- Has no difficulty dressing
- Can put on: Underwear Socks Shirt Pants Shoes
 Can: Button Snap Zip Tie Shoes
- Can undress partially Can undress completely Needs lots of assistance dressing/undressing

Please describe what assistance is needed to (un)dress: _____

Behavior

	Never	Seldom	Often	Explain/Details
Aggressive toward others, throws things				
Bites self or others				
Climbs on tables, etc.				
Crying/screaming at times for unknown reasons				
Difficulty transitioning from activity to activity				
Does not like to be touched				
Enjoys social gatherings				
Grabs others				
Has good manners				
Leaves room without asking/telling				
Prefers to be alone				
Runs away or darts				
Scratches, pinches, or hits				
Self-stimulating sexual behavior				
Spits				
Uses inappropriate words				
Withdraws from group activities				
Other				

Behaviors Continued

It is most beneficial for your child to provide accurate and detailed information to maintain consistent management. Please attach established behavior plans and feel free to add comments on an additional piece of paper.

Please describe in detail these or any other challenging behaviors we should know about _____

What usually triggers challenging behaviors? _____

What are effective responses to challenging behaviors? (Please indicate if more than one staff needs to be present when agitated)

What are two or three effective rewards?

Activities

Fine Motor (involving hands): Arts & Crafts Drawing Painting Puzzles Board Games
 Computer Games Cars, Trucks Dolls Blocks

Sensory (touching, sounds, visual): Play Doh Shaving Cream Music Weighted Activities
 Vibration Singing Uses One Point Vestibular Swing Uses Weighted Vest
 Uses Chewy Doesn't like hands to get dirty

Large Motor (whole body): Taking Walks Running Outdoor Play Swinging Dancing
 Balls Bike Riding Trampoline

Sun Exposure: Participant has very sun-sensitive skin. Participant has somewhat sun-sensitive skin.
 Participant's skin is not sun-sensitive.

Please list participant's favorite activities:

Please list participant's least favorite activities:

Participant Name:

Summer 2024

School Information

School District: Fairport Harbor Painesville City Kirtland Riverside Willoughby-Eastlake
 Madison Wickliffe Perry Mentor Other: _____

My child is expecting to receive ESY (Extended School Year Services). My child will **not** receive ESY (Extended School Year Services).

Please include a copy of your child's most current IEP

Consent for School Record Release

The following must be filled out for all applicants. This release of information form is to give permission for your child's regular school to release a copy of their current IEP to the New Avenues Summer Camp and/or pertinent information from their. Although your child's IEP is not valid during the summer months, staff at New Avenues Summer Camp will use the IEP information to become familiar with your child's ability level and to reinforce goals as much as possible. Thank you for your cooperation!

School Name:	Child's Name:
Teacher's Name:	Child's DOB:
School Address:	City:
State:	Zip Code:

I am requesting the following information/records for the above-named student be released to New Avenues:

- Therapy Evaluations
- Current IEP and ESY goals (if applicable) to focus on during summer camp
- Behavior Plan and Guidelines (if applicable)
- Teacher Information (form included)

Please release information to:

Emily Bloyd
ebloyd@newavenues.net
Children's Programs Director
New Avenues to Independence, Inc.
New Avenues Summer Camp
8090 Broadmoor Ave
Mentor, OH 44060

Signature of Parent/Guardian

Date

Activity Release

I, as a parent or guardian of the Participant, understand that New Avenues to Independence, INC. ("New Avenues") makes efforts to operate and conduct its activities in a safe and responsible manner. These activities include, but are not limited to arts and crafts, music, games, sports, and/or exposure to nature (e.g. weather conditions, animals, plants, insects, etc.). I understand that New Avenue's activities and the actions and/or inactions of other program participants involve certain inherent risks. I recognize these risks and agree to assume all liability for all risks by allowing the Participant to attend New Avenues Summer Camp program and participate in such programs and activities. I hereby release, indemnify, and hold harmless New Avenues, its affiliated entities, their officers, agents, employees, and all other from all liability and/or damages for injury, illness, and/or death sustained by the Participant relating to or deriving in any way from participation in New Avenue's Summer Camp program, whether arising from an act or omission or otherwise, shall be subject to mandatory and binding arbitration clause shall be invalidated, or for any other type of claims and/or causes of action against New Avenues, such as claims.

Signature of Parent/Guardian

Date

Supervision Ratio

I, as a parent or guardian of the participant, understand that New Avenues generally provides supervision of participants at the following participant to staff ratio: 4:1 I understand that if additional support is needed, the parent or guardian must make arrangements with the Summer Camp Director. New Avenues is able to provide 1:1 staffing, 1:2 staffing, or 1:3 staffing for a fee, on a limited basis, or may be able to accommodate a personal care aid to attending with the participant. I understand that the stated ratios do not guarantee that my camper will have a successful camp.

Signature of Parent/Guardian

Date

Medical Release

With my signature, I certify that I will accept emergency services offered by New Avenues for injury and/or illness. I hereby acknowledge that the designated first aid person in charge may perform emergency care and I hereby grant permission to New Avenues to release medical information required by said individual and do hereby give permission for treatment. I understand that medical care will be provided according to the standards of the Ohio Emergency Management Agency and said designated first aid person is protected from liability under the Good Samaritan Act.

Signature of Parent/Guardian

Date

Authorization for Transport

In the event of an emergency, I give permission to transport _____ to the closest medical facility while he/she is attending New Avenues to Independence, Summer Camp.

Signature of Parent/Guardian

Date

Missing Person's Release

I hereby give consent to New Avenues to take a recent photograph of my child and keep it on file to be used in the event a missing person's report must be filed. I also give my consent to New Avenues to release this photograph and other necessary information to the Mentor and/or Ohio State Police and any other agency for the sole purpose of filing a missing person's report. I certify that I have read above and/or had the information read and explained to me.

Signature of Parent/Guardian

Date

Photo Release

I give my permission for New Avenues to Independence to use _____ printed name or photo in:

- Any New Avenues **ELECTRONIC** public relations and social media marketing including but not limited to; A) New Avenues **websites** B) New, Avenues **Facebook** page, and C) New Avenues **LinkedIn** page.

Check the appropriate boxes:

- | | |
|---|---|
| <input type="checkbox"/> You <u>may</u> print my child's name. | <input type="checkbox"/> You <u>may NOT</u> print my child's name. |
| <input type="checkbox"/> You <u>may</u> use my child's <u>photo</u> . | <input type="checkbox"/> You <u>may NOT</u> use my child's <u>photo</u> . |

- New Avenues public relations **Publications** and marketing including, but not limited to; A) monthly and Quarterly **newsletters**, B) **brochures**, C) **annual reports**, and D) **promotional pieces**.

Check the appropriate

- | | |
|---|---|
| <input type="checkbox"/> You <u>may</u> print my child's name. | <input type="checkbox"/> You <u>may NOT</u> print my child's name. |
| <input type="checkbox"/> You <u>may</u> use my child's <u>photo</u> . | <input type="checkbox"/> You <u>may NOT</u> use my child's <u>photo</u> . |

Signature of Parent/Guardian

Date

Participant Name: _____

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Physician Orders

This form must be signed by Parent/Guardian and Physician. Please send enough medication to last the full 5 weeks of camp. If your child is NOT receiving meds at camp, please write “NO MEDS AT CAMP” on this form and sign below. A physician’s signature is not required if your child does not receive meds at camp.

Participant’s Name: _____ DOB: _____ Today’s Date: _____

Doctor Prescribed Medication: (Includes any medication and dietary supplements that are to be given at camp either prescription or over the counter and any medication given on an as-needed basis.)

Name of Medication & Dosage	Reason for Medication	Times	Route	Special Instructions: (i.e. crush, mix with pudding)

I have reviewed the information above and I authorize New Avenues to Independence to administer medication as listed above.

Parent/Guardian’s Signature: _____ Date: _____

Physician’s Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Participant Name: _____

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G-Tube Feeding Form (if applicable)

Must be signed and dated by a physician. Forms can be faxed to 440-602-1030.

Participant's Name: _____ DOB: _____

Address _____
Street City State Zip

Important Notes for Campers Using G-Tubes:

- All medications and dietary supplements (such as Ensure) **must** be listed on the Physician Orders form.
- Campers must bring their own supply of syringes, pumps, bags, and other g-tube supplies. Supplies are **not** provided by camp
- All supplies must be turned into the nurse on or before the first day of cam

Does this camper use a pump? Yes No If no, please describe how feeding and medication is to be given.

Can this camper have anything by mouth? Yes No If yes, please describe.

Please describe the mealtime procedures including frequency and type of flush that should be given:

Additional Notes:

Be sure to use this form as a supplement to the medical form. Both forms MUST be turned in, and medication received, prior to the camper's arrival.

Physician Signature: _____ Date: _____

Physician Name/Title (printed): _____

Address: _____ Phone: _____

Participant Name:

Summer 2024

		Services Requested	Total
Lake County Residents			
ESY Services	\$2,500	<input type="checkbox"/>	\$
Without ESY Services	\$2,000	<input type="checkbox"/>	\$
Out of County Residents			
ESY Services	\$2,700	<input type="checkbox"/>	\$
Without ESY Services	\$2,200	<input type="checkbox"/>	\$
Therapy Services (\$70/30 min session)			
Occupational Therapy			
Weekly	\$350	<input type="checkbox"/>	\$
Twice Weekly	\$700	<input type="checkbox"/>	\$
Physical Therapy			
Weekly	\$350	<input type="checkbox"/>	\$
Twice Weekly	\$700	<input type="checkbox"/>	\$
Speech Therapy			
Weekly	\$350	<input type="checkbox"/>	\$
Twice Weekly	\$700	<input type="checkbox"/>	\$
1:1 Aide Services			
Service Fee	\$150	<input type="checkbox"/>	\$
*Please see Camp Director for all costs associated with 1:1 Services			
Participant Total Cost			\$

Applicant Information	
Name:	
Residential Address:	
County of Residence	
School District:	
District Contact:	
District Email:	
District Phone Number:	
Parent/Guardian Name:	
Parent/Guardian Phone No:	
Parent/Guardian Email:	

Party Responsible for Payment	
Participant Family	
Participant School District	
Other	

Payment Method			
<input type="checkbox"/> Check	Payable to:	New Avenues to Independence	
		3615 Superior Ave. E.	
		Suite 4404A	
		Cleveland, OH 44114	
<input type="checkbox"/> Credit Card	Cardholder Name:		
	Card Number:		
	Expiration Date:		
	3 Digit CVC:		
	Zip Code:		

