

Southampton Fresh Air Home

36 Barkers Island Road, Southampton, New York 11968

Camp Phone: (631) 283-1594

Camp Fax: (631) 283-1620

dbillingham@sfah.org

www.sfah.org

Enrollment for Summer Camp 2011

****New applicants please include a photo of your child from the past 6 months****

This is my first time applying to the Southampton Fresh Air Home Yes No

Camper's name _____ / _____ / _____
First name M.I. Last name

He/she likes to be addressed as: _____

Birth date: ____/____/____ Male ____ Female ____ Age on June 1, 2011: ____

Camp dates: Please number sessions in order of preference: (1st, 2nd & 3rd)

Session 1 (ages 10-18): ____ Sun June 26 - Sat July 16 (21 days)

Session 2 (ages 8-18): ____ Wed July 20 - Wed July 27 (8 days)

Session 3 (ages 8-16) ____ Sun July 30 - Sat Aug 20 (21 days)

Guardian Information (1):

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: () _____

Relationship to camper: Mother Father Legal Guardian

Guardian Information (2):

Name: _____

Email: _____ Cell: Phone: () _____

Relationship to camper: Mother Father Legal Guardian

Name of person completing form if different from parent/guardian: _____

Relationship to Camper: _____ Tel: () _____

Are the camper parents divorced? Yes No

If parents are divorced or separated:

Who has legal custody of the child? _____

Does anyone have restricted access to the child? _____

To whom should camp mailings/billings be sent? _____

Where does the camper regularly live?

With biological family with a relative with adopted/foster family

School Information:

School: _____ Tel: () _____

Address: _____ City: _____ State: _____ Zip: _____

Teacher: _____ Grade: _____

School Type:

Spec Ed Facility **ONLY**

Mainstream Ed Facility

Mainstream Ed Facility w/special Ed classes

Does your child have an aid while at school? Yes No

Please list TWO people we may call for information about your child: **One must be a teacher**

(1) Name: _____ Relationship: _____

Tel: () _____ Email: _____

(2) Name: _____ Relationship: _____

Tel: () _____ Email: _____

Camp Experience:

Has your child attended the Southampton Fresh Air Home before? Yes No

Has your child been to camp before? Yes No If yes please list: _____

Did you child have any problems at camp? Yes No

If yes please describe: _____

How did you hear about the Southampton Fresh Air Home? _____

Transportation:

The Southampton Fresh Air Home is able to provide limited transportation. Only request help if you have no alternate way of transporting your child to camp.

1. I will provide my childs transport to camp.....Yes No

2. My child needs to stay in his/her wheelchair during transportation Yes No

Therapy Information:

Please list any therapists your child has seen within the past 2 years

Physical Therapist Occupational Therapist Psychologist

Psychiatrist Counselor Social Worker

Please describe counseling/therapy services your child receives. _____

The camp does not supply PT services although if your child requires PT while at camp please contact us for names of local therapists that you may contract with independently. There is a private space at the camp for treatment.

Medical Information:

Medical Diagnosis: Cerebral Palsy Spina Bifida Learning Disability
Autism Mental Retardation (mild/moderate/profound) Other (specify)

Primary Care Physician: _____ Tel: _____

Is medication taken regularly? Yes No If yes, Parent/Guardian please complete:

Medication Name	Dosage	Times Given	Reason

Is there a special way to administer medicine? _____

Any allergies? (food/meds/environmental) _____

Does your child require an epi-pen for allergies? Yes No

Has your child ever had a seizure? Yes No

If yes when was last seizure? _____

Has your child been diagnosed with a seizure disorder? Yes No

How frequently do seizures occur? _____

Has your child had surgery or been admitted to hospital in the past 6 months? Yes No

If yes, please describe _____

Are there any physical restriction due to this admission? Yes No

Is your child tube fed? Yes No

At home does your child require an overnight nurse/aid? Yes No

Does your child need to be catheterized? Yes No

Behavioral Information:

Hits/Bites/Attacks Others: Never Sometimes (please explain) Often (please explain)

Self destructive? Never Sometimes (please explain) Often (please explain)

Tantrums? Never Sometimes (please explain) Often (please explain)

Runs Away? Never Sometimes (please explain) Often (please explain)

General Physical Care Information:

Appearance: Height: _____ Weight: _____ lbs

Mobility (please check all that apply):

- | | |
|----------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Walks freely | <input type="checkbox"/> Walks with difficulty/using aids |
| <input type="checkbox"/> Uses wheelchair sometimes | <input type="checkbox"/> Uses wheelchair full time |
| <input type="checkbox"/> Uses electric wheelchair | <input type="checkbox"/> Uses manual wheelchair |
| <input type="checkbox"/> Needs to be pushed | <input type="checkbox"/> Can self propel |
| <input type="checkbox"/> Wears braces: type _____ | |

Dressing (please check all that apply):

- | | |
|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Need no help | <input type="checkbox"/> Needs total help dressing |
| <input type="checkbox"/> Needs some help: describe _____ | |

Bathing (please check all that apply):

- | | |
|----------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Need no help | <input type="checkbox"/> Needs total help bathing |
| <input type="checkbox"/> Needs some help: describe _____ | |

Transferring (please check all that apply):

- | | |
|----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Need no help | <input type="checkbox"/> Needs total help transferring |
| <input type="checkbox"/> Needs some help: describe _____ | |

Toileting (please check all that apply):

- | | |
|-----------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Bowel Incontinent |
| <input type="checkbox"/> Bladder Incontinent | <input type="checkbox"/> Wears diapers for trips only |
| <input type="checkbox"/> Wears diapers- nighetimes only | <input type="checkbox"/> Wears diapers- all the time |
| <input type="checkbox"/> Regularly takes suppositories | <input type="checkbox"/> Needs transferring to the toilet |
| <input type="checkbox"/> Maintains a bowel program | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Please describe all marked _____ | |

-
- | | | |
|--------------------------------------------------|---------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Need to be catheterized | <input type="checkbox"/> Needs help catheterizing | <input type="checkbox"/> Self-catheterizes |
|--------------------------------------------------|---------------------------------------------------|--------------------------------------------|

Eating (please check all that apply):

- | | |
|-----------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Needs no help | <input type="checkbox"/> Needs some help |
| <input type="checkbox"/> Needs to be fed | <input type="checkbox"/> Needs food cutting |
| <input type="checkbox"/> Needs food blending | <input type="checkbox"/> Uses special utensils |
| <input type="checkbox"/> Special Medical Diet | <input type="checkbox"/> Special Diet other (vegetarian, kosher etc) |
| <input type="checkbox"/> Tube Fed | <input type="checkbox"/> Needs special food to be provided. |
| <input type="checkbox"/> Please describe all marked _____ | |
-

Sleeping (please check all that apply):

- | | |
|---------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> No problem | <input type="checkbox"/> Some problems |
| <input type="checkbox"/> Has trouble falling asleep | <input type="checkbox"/> Wakes early (before 6am) |
| <input type="checkbox"/> Makes noise | <input type="checkbox"/> Requires turning |
| <input type="checkbox"/> Uses bedrails | |
| <input type="checkbox"/> Please describe all marked including full details of regular turning schedule: | |

Communication (please check all that apply):

Speech:

- | | |
|-----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Some speech problems |
| <input type="checkbox"/> Hard to understand | <input type="checkbox"/> Non-verbal. |
| <input type="checkbox"/> Please describe all marked _____ | |

Will your child be bringing a communication aid to camp? Yes No

If yes please list type _____

Hearing:

- | | |
|-----------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Wears hearing aids | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> Please describe all marked _____ | |

Vision:

- | |
|------------------------------------------------------------------------------|
| <input type="checkbox"/> No problems |
| <input type="checkbox"/> Wears glasses |
| <input type="checkbox"/> Legally blind |
| <input type="checkbox"/> Please describe when your child wears glasses _____ |

Insurance Information

Camper has full medical insurance coverage: Yes No

If accepted you will be required to submit a copy of current insurance and prescription cards.

Fees:

Upon acceptance there is a non-refundable deposit.

PLEASE DO NOT SEND ANY MONEY WITH THIS APPLICATION.

The fees for 2010 are listed below. Fees for 2011 will be available shortly.

We encourage every parent, regardless of financial background, to discuss our scholarship program with us before making any decisions.

Deposit Amount: \$60 (due after a camper is accepted)

Tuition for Session 1: \$2300 for returning campers and \$2600 for new campers. (Due May 16)

Tuition for Session 2: \$900 for all campers (Due May 16)

Tuition for Session 3: \$2300 for returning campers and \$2600 for new campers. (Due May 16)

The Southampton Fresh Air Home has a financial aid program. Please contact David Billingham for further information at (631) 283-1594. You do not need to submit a financial aid application with this application. Financial aid applications will be mailed once a camper has been accepted into camp.

All the information provided by me, or any other person, on this form is true, accurate and complete to the best of my knowledge. If I am asked, I agree to give proof that any information is correct.

PRINT Camper's name

SIGNATURE of camper if 18yrs+

PRINT name of parent/guardian

SIGNATURE of parent/guardian

IMPORTANT

If your child is accepted you will be sent a packet that will include the following:

- Legal Forms (to be notarized)
- Camper Physical (to be dated after Jan 1, 2011)
- Financial Aid application (if applicable)

All paperwork is subject to submission dates. Your child's place at camp is not guaranteed unless we receive all paperwork by the stated deadlines.

Please do not send any money with this application

All new applicants please complete the last page and submit a current picture of your child.

Please take a moment to share The Southampton Fresh Air Home with a friend. If you or your child knows anyone who should learn about SFAH, please write their names and addresses below. We will promptly send them information. Thank you.

Name: _____

Name: _____

Address: _____

Address: _____

Tel: _____

Tel: _____

Southampton Fresh Air Home
A Camp for Physically Challenged Children
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Camp Phone: (631) 283-1594
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Website: www.sfah.org
E-Mail: dbillingham@sfah.org

Dear Parent/Guardian:

It is the policy of the Southampton Fresh Air Home to observe all new children who are applying to camp, whenever possible. We like to visit the school/program and talk to teachers involved with your child. The school legally needs your consent for this visit allowing us to view the files and take a photo. Please complete the form below and submit it with the application.

SFAH will schedule visits directly with your child's school.

Sincerely,

David Billingham
Camp Director

TO WHOM IT MAY CONCERN:

(Child's name)

has applied to the Southampton Fresh Air Home summer residential camp. Part of the application process involves the Director, or other camp personnel, observing my child, talking to educators, and other individuals involved with the care of my child.

I hereby give my permission for this visit, access to relevant files, and photo if necessary.

Signature

Date