

# 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](mailto:dbillingham@sfah.org)

[www.sfah.org](http://www.sfah.org)

## Enrollment for Summer Camp 2012

**\*\*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

Campers name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First name M.I. Last name

He/she likes to be addressed as: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Age on June 1, 2012: \_\_\_\_

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

Session 1: \_\_\_\_ Sun June 24 - Sat July 14 ( 21 days )

Session 2: \_\_\_\_ Wed July 18 - Wed July 25 ( 8 days )

Session 3: \_\_\_\_ Sun July 29 - Sat Aug 18 ( 21 days )

I am interested in more than one session for my child.\* Yes  No

*\*It is very difficult for us to place a camper in Sessions 1 **and** 3. Parents interested in more than one session should only mark yes if they are also interested in Session 2.*

### Guardian Information (1):

Name: \_\_\_\_\_

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

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

Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Relationship to camper:  Mother  Father  Legal Guardian

### Guardian Information (2):

Name: \_\_\_\_\_

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

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

Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Relationship to camper:  Mother  Father  Legal Guardian

Are the campers parents divorced? Yes  No

Does anyone have restricted access to this child? Yes  No

Where does the camper regularly live?

With biological family  with a relative  with adopted/foster family

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

Relationship to Camper: \_\_\_\_\_ Tel: ( ) \_\_\_\_\_

**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? \_\_\_\_\_

Does your child have friends attending camp that they hope to be placed with? If yes please list their names: \_\_\_\_\_

**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. Requesting transportation will not affect your application.

1. I will provide my child's 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

Does your child have a tracheotomy? Yes  No

Does your child use a sleep aid, e.g. a BiPAP 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)

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**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"/> Need to be catheterized          | <input type="checkbox"/> Needs help catheterizing         | <input type="checkbox"/> Self-catheterizes |
| <input type="checkbox"/> Please describe all marked _____ |   |  |

**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):**

- No problem
- Has trouble falling asleep
- Makes noise
- Uses bedrails
- Some problems
- Wakes early (before 6am)
- Requires turning
- Please describe all marked including full details of regular turning schedule:

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**Communication (please check all that apply):**

**Speech:**

- No problems
- Hard to understand
- Please describe all marked \_\_\_\_\_
- Some speech problems
- Non-verbal.

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

If yes please list type \_\_\_\_\_

**Hearing:**

- No problems
- Wears hearing aids
- Please describe all marked \_\_\_\_\_
- Hearing Impaired
- Deaf

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**Vision:**

- No problems
- Wears glasses
- Legally blind
- Please describe when your child wears glasses \_\_\_\_\_

**Insurance Information**

Camper has full medical insurance coverage: Yes  No

**Fees:**

Upon acceptance there is a non-refundable deposit.

**PLEASE DO NOT SEND ANY MONEY WITH THIS APPLICATION.**

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

Tuition for Session 1: \$2500 for returning campers and \$3000 for new campers.

Tuition for Session 2: \$1000 for all campers

Tuition for Session 3: \$2500 for returning campers and \$3000 for new campers.

The Southampton Fresh Air Home has a scholarship 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 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- notarized
- Camper Physical
- 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: \_\_\_\_\_

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*A Camp for Physically Challenged Children*  
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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

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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