Camp Connect 2016
An Inclusive Camp for Children with ASD
Fully Sponsored by Southeast Parent Advisory Committee

University Autism Center
611 N. Fountain St.
Cape Girardeau, MO 63701
(573) 986-4985
www.semo.edu/autismcenter

June 6-10 Ages 5-8
9:00-3:30 Monday-Friday

June 13-17 Ages 9-13

5 Day outings to St. Louis area attractions for Ages 13-22 tentatively planned for June 28, July 17, 19, 26, and August 2nd

Application due April 15, 2016
(Acceptance notification sent by April 30
Based on availability of support & space)
Application & Materials Fee: $25

Bring a Friend/Buddy*
*Friends/Buddies are encouraged to promote typical social interactions. Siblings as buddies ONLY when beneficial to objective of camp – inclusive experience for all and beneficial to camper.
Max 1 buddy per camper - (A buddy could be a sibling, or other relative, friend or neighbor who attends with the camper)

Directed by
Dr. Nancy Aguinaga,
and School Leaders

Assisted by
University Students

Building Friendships, FUN,
Swimming, Adventure, Field Trips

Camper Application and Profile
Application Deadline: April 15, 2016

- All sections of the application and profile must be completed with application fee submitted for enrollment to be complete. For your child’s safety and enjoyment, be sure to provide full dietary, medical, behavioral, and communication information.
- Applications will be accepted and reviewed on a ‘first come-first served’ basis with application fee and complete application. Notification of acceptance will be sent by April 30th based on availability of support and space.
- A separate Enrollment Application and Camper Profile must be completed for each child, including Buddy Campers.
- Campers must bring a sack lunch and swimsuit and towel most days.
CAMP CONNECT 2016
Enrollment Application

Will a buddy be attending?  Yes[ ]  No[ ]
If yes, complete buddy section

Name of Camper: _____________________________________ Date of Birth: _______________________

* A separate Enrollment Application and Camper Portfolio must be completed for each child.

Parent/Guardian Information

Name____________________________________ Name____________________________________
Home Phone ______________________________ Home Phone ______________________________
Work Phone __________________________________ Work Phone __________________________________
Cell______________________________________ Cell______________________________________
Email___________________________________ Email___________________________________
Address __________________________________ Address __________________________________
City, State, Zip____________________________ City, State, Zip____________________________

Medical Background

Physician's Name:_________________________________ Phone________________________
Does child have physical restrictions/limitations?   yes[ ] no[ ] If yes, what: ______________________________
Is your child subject to seizures?   yes[ ] no[ ] Type: ______________________________ Frequency: ______________________________
Other Special Conditions: ______________________________________________________________
Is child toilet trained?   yes[ ] no[ ]
Does child need assistance with toileting?   yes[ ] no[ ] If yes, please explain: ______________________________
Allergies to drugs, foods, insects?   yes[ ] no[ ] If yes, what? ______________________________
Is child on a special diet?   yes[ ] no[ ] If yes, please explain: ______________________________
Is child taking medication:   yes[ ] no[ ] NOTE: If yes, please complete medication information in this packet.
Last Tetanus shot date: __/__/__
Medical Insurance Company for child: ________________________________________________________
Insurance Policy Phone:________________________ Policy Number:_____________________________

Other than information included on this form, are there other things emergency personnel need to now about your child before treating or transporting? __________________________________________________
______________________________________________________________________________________

Emergency Contact Information: Please list whom to contact, if needed, regarding an emergency involving your child.

Name:______________________________________ Relationship:________________________
Best #:______________________________________ Second #:________________________

Name:______________________________________ Relationship:________________________
Best #:______________________________________ Second #:________________________

Name:______________________________________ Relationship:________________________
Best #:______________________________________ Second #:________________________

People permitted to pick up your child

1. Name:_________________________ Phone:________________________
2. Name:_________________________ Phone:________________________
**Communication:** Please send any communication system used by your child to camp daily.

- Completely Verbal
- Some Language/Verbal*
- Nonverbal*
- Sign Language*
- Picture Symbols/Exchange
- Communication Board
- Communication Device (name):

*Please indicate how your child communicates his/her needs. For example: points to things, becomes very loud when upset, says “red” for “juice,” etc.

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**Major Dislikes** – List things that your child does not like or to avoid. Example: loud noises, water, sand, etc.

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

**Major Likes** – List things that your child really likes. Example: play dough, books, animals, etc.

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

**Fears** – List things that your child is very afraid. Examples: animals, thunder, rain, men with hats, etc.

1. 
2. 
3. 
4. 
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In order for our experienced staff to safely support and manage your child at camp and in the community, all of your child’s current or potential behaviors that may adversely affect him/her or others, must be identified. We will conference with you for a reasonable solution in the event we have extreme difficulty managing your child’s behaviors, which may include dismissal from Camp Connect for this year.

**Behaviors:** List any behaviors that may occur at camp. **Include a copy of your child’s individual behavior plan (if applicable) with the completed application form.**
Camper’s Name: __________________________________________

Indicate Desired Attendance:  June 6-10, 2016 □  June 13-17, □ 2016  Week 3 dates □

Name of Buddy: __________________________________________ Date of Birth: _______________________

Parent/Guardian Information
Name____________________________________  Name____________________________________
Home Phone ______________________________  Home Phone ______________________________
Work Phone ______________________________  Work Phone ______________________________
Cell _________________________________  Cell _________________________________
Email ___________________________________  Email ___________________________________
Address ___________________________________  Address ___________________________________
City, State, Zip ____________________________  City, State, Zip ____________________________
Medical Info if needed:_______________________  Emergency contact if different than above:______________________
____________________________________________________________________________________
____________________________________________________________________________________

CAMP CONNECT

Please circle your child’s T-shirt size and buddy’s (if applicable)

Kids-
SMALL  MEDIUM  LARGE  XL

Adult-
SMALL  MEDIUM  LARGE  XL  XXL  XXXL

Application Payment

Application Fee Paid:  $_________

TOTAL DUE BY MAY 15, 2016:  $_________

Application Submission

Applications accepted and reviewed on a first-come first-served basis with deposit and complete application.
Notification of acceptance will be sent by April 30 based on availability of support and space.

Applications must be submitted by April 15, 2016
Notification of acceptance will be made by April 30, 2016

Mailing Address:
Southeast Missouri State University Autism Center
One University Plaza
Mail Stop 9450
Cape Girardeau, MO 63701

Fax: 573-986-4994
Email: cburnett@semo.edu

Daily Activities start and end at the University Autism Center
Physical Address:
611 North Fountain St.
Cape Girardeau, MO 63701

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Southeast Missouri State University Autism Center (573) 986-4985 www.semo.edu/autismcenter
I understand registrations may be submitted by mail or in person, and registrations by telephone will not be accepted. I understand that to register I must complete the Enrollment Application and send a $25.00 per week per camper deposit. (Incomplete applications and/or applications without proper deposits will not be accepted.) I understand payments will be processed as they are received, but this does not guarantee placement for my child. Registration is on a first come, first served basis. The $25.00 deposit will be retained in the event of cancellation or inability to attend. I am aware this camp is not a Public School Program.

I hereby give my consent for ___________________________ to participate in CAMP Connect.

Child’s Name

In consideration of my child being permitted to participate in this camp, I hereby release, waive, and discharge CAMP CONNECT, its agents and employees from all liability for injuries, loss or damages, and any claims for damage on account of any injuries to my child or his/her property while participating in CAMP CONNECT. I have provided the program with information regarding all medications and all dosages required during program hours. I also agree to emergency treatment by a physician or hospital in the event that I cannot be reached.

Participant’s Parent/Guardian _________________________________     Date___________________

PHOTO RELEASE

I hereby grant permission for the above stated Camp participant to appear in still or motion pictures for educational, promotional, or other proper purposes only. _____ Yes _____ No

Participant’s Parent/Guardian _________________________________     Date___________________

TRAVEL RELEASE

I hereby grant permission for the above stated Camp participant to travel on a university bus or rented van for swimming and on field trips to various locations. I understand that Camp personnel supervision during transportation and field trips, and that one on one staffing is not possible. I understand that field trips depart per the schedule, and no one will accept my child at the camp location after the bus has left. I also understand no refunds will be provided for days on which my child has missed the bus for pool or field trips.

Participant’s Parent/Guardian _________________________________     Date___________________

SWIM RELEASE

I hereby grant permission for the above stated Camp participant to swim in a community pool. I understand that campers will be tested for swimming ability on their first day of camp. Those campers that the counselors/pool staff feel are not competent swimmers will need to bring Coast Guard approved flotation devices which should be supplied by parents/guardians. I understand that no campers may stay behind at camp during swim or field trips. [Swimming is not a guaranteed activity of the camp as it is subject to pool availability]

Participant’s Parent/Guardian _________________________________     Date___________________
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Child’s Name

In consideration of my child being permitted to participate in this camp, I hereby release, waive, and discharge CAMP CONNECT, its agents and employees from all liability for injuries, loss or damages, and any claims for damage on account of any injuries to my child or his/her property while participating in CAMP CONNECT. I have provided the program with information regarding all medications and all dosages required during program hours. I also agree to emergency treatment by a physician or hospital in the event that I cannot be reached.

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Participant’s Parent/Guardian ______________________________     Date___________________

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Participant’s Parent/Guardian ______________________________     Date___________________
### Medication Information

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Time</th>
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<tbody>
<tr>
<td>1. _____</td>
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<td>3. _____</td>
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