Camp SOCIAL 2015
A Social Cognition Camp for Youth with HFA
Sponsored by Southeast Missouri Autism Project Parent Advisory Committee

SESSION 2
Dates: July 13-17, 2015

Monday through Friday
8:30 am to Noon

Camp Tuition: PAID by SE PAC*

Registration and Materials Fee: $25
Registration Fee must be received with application

Ages 10-16 Divided in Groups
(limited Camper slots available)

Fully Sponsored by
Southeast Missouri Autism Project
Parent Advisory Committee*
SE PAC Meets Monthly at the University Autism Center

Camp SOCIAL is a specialized skill development camp for high-functioning individuals with an Autism Spectrum Disorder in need of developing or enhancing their social communication skills. Campers will be assigned to groups of peers similar in age and social awareness and will experience a variety of activities designed to develop and practice social communication skills and strategies.

Due to the therapeutic nature of this camp, space is limited. Applications must be received by May 29, 2015 to be given full consideration and must be received with the registration and materials fee. Registration is limited to 12 campers with first consideration to earliest applicants. Campers will be notified of acceptance by June 12, 2015. Please contact the University Autism Center to obtain an application: (573) 986-4985.
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 __________________________________ 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:_________________________________________________________________
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 and sign Medication Release 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 know 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:_______________________________
*In order for our experienced staff to safely support and manage your child at camp and on campus, 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 SOCIAL for this year, with a cancellation refund.

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

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

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

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

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

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

**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.
Camp SOCIAL 2015

Registration Payment

Camper’s Name: ____________________________ Date of Birth: ____________________

Special Thanks to Our Sponsor:

Southeast Missouri Autism Project Parent Advisory Committee (SE PAC)

The Southeast Missouri Autism Project serve individuals through the Poplar Bluff and Sikeston Regional Offices; Programs and services offered through the Autism projects are designed to assist in skill development of individuals with ASD and provide needed training and support for families. The SE PAC meets monthly at the University Autism Center. We are grateful for their generous support.

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Camp SOCIAL T-shirt

Please circle your child’s T-shirt size

<table>
<thead>
<tr>
<th>Kids-</th>
<th>SMALL</th>
<th>MEDIUM</th>
<th>LARGE</th>
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</thead>
<tbody>
<tr>
<td>Adult-</td>
<td>SMALL</td>
<td>MEDIUM</td>
<td>LARGE</td>
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Registration Submission

* Registrations accepted first come-first served with deposit and complete application.
* Incomplete applications or those without deposit will be placed on a wait list.
* Confirmation will be sent upon receipt of complete registration and deposit with notification of acceptance.

Application, Registration and $25.00 Fee must be returned by May 29, 2015

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

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

Daily Activities start and end at the University Autism Center
Physical Address:
611 North Fountain St.
Cape Girardeau, MO 63701
I understand registrations may be submitted only 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 deposit per each camper being registered. (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 herby give my consent for ________________________________ to participate in Camp SOCIAL.

Child’s Name

In consideration of my child being permitted to participate in this camp, I herby release, waive, and discharge Camp SOCIAL, 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 SOCIAL. 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 herby 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___________________
Medication Release

I give permission for my child (aka Camper), ____________________________, to have his/her oral medication administered to him/her during camp hours by a Camp SOCIAL staff person.

Medication must be provided in its original container from pharmacy with dosage amount, directions, and prescribing physician name. If not, medication will not be administered.

<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>2._________</td>
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<td>3._________</td>
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Special Instructions for administering medication:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Child’s Parent/Guardian ___________________________________________ Date ____________