



Anne Learsen  
CENTER

Nurturing abilities. Changing lives.

APPLICATION DEADLINE: MAY 1, 2010

TechnoCamp  
2010  
June 27--July 2  
Camp Grassick

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Primary Diagnosis \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ (Home)  
\_\_\_\_\_ (Work)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ (Home)  
\_\_\_\_\_ (Work)

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ (Home)  
\_\_\_\_\_ (Work)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ (Home)  
\_\_\_\_\_ (Work)

Primary Care Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Consultants: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Hay fever    | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Sinus          | <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Fainting               |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Chickenpox   | <input type="checkbox"/> Measles                |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Bedwetting     | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Mumps                  |
| <input type="checkbox"/> Sleep walking  | <input type="checkbox"/> Pneumonia    |   |

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last Tetanus/ Diptheria immunization \_\_\_\_\_

Does your child have any history of seizures? Yes/No  
If so, please describe seizure activity, etc. \_\_\_\_\_  
\_\_\_\_\_

Are the seizures controlled? Yes/No

Seizure medications: \_\_\_\_\_

Medications: (include times, route, etc)

Medications: How are medications given?

Allergies

Medications: \_\_\_\_\_

Other allergies/ intolerances:

Procedures to avoid:

Diet/Special considerations/special utensils:

Foods to avoid and why:

Special Technology/Devices (ie, gastrostomy tube/button, Baclofen pump, VP shunt, VNS stimulator):

Any other pertinent information:

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Disability Information

Complete this section if the applicant has a physical disability or is blind/low vision. Upon acceptance, applicant must complete a physical prior to attending camp. **ACCC will send a detailed medical form for applicant and physician to complete.**

List all type(s) of physical disability:

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List any other disorders:

(communication disorders, mental disabilities, emotional disorders, learning disabilities, etc.) \_\_\_\_\_

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The applicant walks

- Alone  
 With help  
 Does not walk

The applicant uses (please check)

- Electric Wheelchair  
 Manual wheelchair  
 Needs assistance pushing wheelchair  
 Walker  
 Other(explain) \_\_\_\_\_

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Does the applicant have any splints or braces that will be used during the camp? Please give type and usage.

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Does the applicant use a water safety device? Yes/No

If yes, please describe. \_\_\_\_\_

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Please describe the applicant's swimming abilities. \_\_\_\_\_

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\_\_\_\_\_ My child may participate in boating activities. **Parent/Guardian Initial** \_\_\_\_\_

## Activities of Daily Living

In order for us to meet needs for assistance, the following information is requested. Please check appropriate level of care required in each of the following categories:

	No Assistance	Supervision	Partial Assist	Total Assist
Dressing				
Hygiene/ grooming				
Bowel routine				
Bladder routine				
Eating				
Bathing				
Night turns				
Bed transfers				
Toilet transfers				

Does this child need bed rails? Yes/No

How much time is taken daily for personal care needs (hours and minutes)?

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Describe any additional assistance needs:

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### CABIN ROOMMATE REQUESTS

All applicants fill out this section.

No roommate preference

The applicant would like to room with:

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*Please have requested roommate list you in return or we will not be able to honor request. Note: We reserve the right for final placement based on capacity.*

# Behavior Information

*All applicants must complete this section.*

Are you or your child part of a behavior management program? Yes/No  
If yes, please list name and phone number of specialist below:

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## SOCIAL STUDY

1. Personal traits: If possible, please give some evaluation of this child's maturity level, self-esteem, and attention span and fatigue level.

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2. Social adjustment: How does this child get along in the home, in school, and with other children? (Relationship to parents, siblings, peers?)

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3. Discipline: Does this child exhibit any unusual discipline problems in his/her home environment? Yes/No  
If yes, please explain.

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4. Please list a few interests or hobbies of the child.

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5. Do you feel this child can adjust being away from home and in a camp environment?

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## Communication

Please indicate method(s) of communication used by the applicant:

Yes No

Is he/she able to talk?

Do he/she use a communication device?

Type of device: \_\_\_\_\_

Access method: \_\_\_\_\_

Describe use of device:

Answers questions with device

Makes requests with device

Generates own ideas on device

Needs pre-programmed displays for the device

Can this device be brought to camp?

Is he/she able to understand what is said?

Is his or her speech understandable?

## Speech and Language

Complete this section if the applicant has a speech or language impairment.

Briefly describe the applicant's communication disorder. (State in your own words.)

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Is the applicant now receiving speech/language help? Yes/No

How long? \_\_\_\_\_

Speech: Check any of the following statements that apply to the applicant:

Cannot be understood

Has voice problems

Cannot say some sounds clearly

Has a cleft palate

Stutters

Language: Check any of the following that apply to the applicant:

Listening: has difficulty understanding the communication of other people

Speaking: has difficulty expressing ideas vocally

Grammar: has difficulty understanding and putting sentences together

Writing: has difficulty expressing thoughts in written form

Vocabulary: has difficulty using and understanding new words

Reading: has difficulty comprehending written messages

Receptive language: has difficulty comprehending both spoken and written language

Expressive language: has difficulty in using both spoken and written language to communicate with others

**HEARING IMPAIRMENT**

Check all of the following statements that apply to the applicant:

- Uses hearing aid part time / full time (circle one)
- Uses sign language
- Can hear telephone conversations

Amount of hearing loss

- Total (no usable hearing)
- Severe (little usable hearing)
- Hearing impaired (some hearing with hearing aid)

How long has the applicant had the hearing loss?

\_\_\_\_\_

**VISUAL IMPAIRMENT**

Does the child have a vision impairment? Yes/ No

If yes, please describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please attach a current IHP/IEP and Behavior plan if this is a first time applicant.**

**How did you hear about theCamp?**

- |   |  |
|---|--|
| <input type="checkbox"/> Newspaper          | <input type="checkbox"/> Child's physician       |
| <input type="checkbox"/> Radio              | <input type="checkbox"/> ACCC's website          |
| <input type="checkbox"/> Child's teacher    | <input type="checkbox"/> Other (Please indicate) |
| <input type="checkbox"/> Child's caseworker | _____  |

**Upon acceptance, child will be sent the physical form, camper checklist and schedule, financial and release forms.**

**PLEASE SEND COMPLETED APPLICATION TO:**

**Theresa Hanson  
 Anne Carlsen Center  
 701 3<sup>rd</sup> St NW  
 PO Box 8000  
 Jamestown, ND 58402**

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