



Autism Society of Greater Cleveland

P.O. Box 41066, Brecksville, OH 44141

(216) 556-4937 support@asgc.org (e-mail)

www.asgc.org (website)

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ASGC Social Skills Summer Camp 2009

Enrollment Form ASGC Summer Social Skills Camp 2009

CHOOSE ONE:

- _____ Session One (ages 6-12) July 6 thru July 10, 2009: 9:00 AM - 2:00 PM
_____ Session Two (ages 13 -18) July 13 thru July 17, 2009: 9:00 AM - 2:00 PM

Camp Location: City of Independence Old Recreation Bldg.
6200 Elmwood Avenue
Independence, OH 44131

Located within City of Independence Park, west of Brecksville Road, South of I-77 Rockside Road
(If necessary, all camp experiences and teacher/student staffing will be adjusted and developed according to age population)

Participant's Name	Birth date	Age	School Attending	Grade
Mother/Guardian's Name	Address	City	Zip Code	Home Phone/Work Phone
Daytime Phone Number	Cell Phone #	E-mail Address		
Father's/Guardian Name	Address	City	Zip Code	Home Phone/Work Phone
Daytime Phone Number	Cell Phone #	E-mail Address		

Parent or Legal Guardian's Initials: _____



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AUTHORIZED PICK UP INFORMATION:

Should your child become ill during the Camp, please list 4 people who you would authorize to pick up your child from the Camp Program. Please remember to include yourself, spouse, family members, etc.:

Authorized Name (s)	Relationship	Daytime Phone/Cell Phone

**A photo ID must be presented to the Camp Staff before your child will be released.
Children WILL NOT be released to any person Not listed on the Registration Form.**

Mother/Guardian Signature	Date	Father/Guardian Signature	Date

PROGRAM LOCATION:

- This Program is held in the City of Independence Old Recreation Building, 6200 Elmwood Avenue, Independence, OH 44131. The Old Recreation building is located within the city park. It has access to a pavilion, playground, baseball, soccer fields and basketball courts. It includes full kitchen/bathroom areas. There are three separate rooms to accommodate teaching, play and quiet area. The park is located West of Brecksville Road, South of Rockside Road (I-77/480).
- Participants must be signed in upon arrival.
- Participants will be walked to their cars by a certified teacher upon dismissal.

Participants full name: _____

Parent or Legal Guardian's initials: _____



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TRANSPORTATION:

- Parents/Guardians must provide transportation to and from Camp.

REGISTRATION FEES:

- Camp fees are \$250.00 per week (Cash or Check)
- Please Make Check Payable to Autism Society of Greater Cleveland (ASGC)
- BE SURE TO INCLUDE A CURRENT COPY OF YOUR CHILD'S IEP & MFE WITH ENROLLMENT MATERIAL.
- Mail Completed Forms, IEP & MFE with \$250 Fee to ASGC, P.O. Box 41066, Brecksville, OH 44141
- Fees are due upon Registration
- Registration Deadline is June 20, 2009
- All Fees are non-refundable.

COME READY FOR CAMP:

- Children should come dressed, fed and ready for camp.
- Snacks/Lunch/Drinks need to be provided and sent from home.
- All items from home, including back packs, and lunch items should be clearly marked with the child's name.
- Please be sure to use sun screen for your children as they will be outside.
- The ASGC cannot be held responsible for any items that are brought from home.

DISCIPLINE & GUIDANCE POLICY:

- Because we have a responsibility to insure the safety of and provide positive experiences for all children in the program, children are expected to abide by the rules of this program as well as respect the rights of other children.
- Our goal with discipline is that each child develop increasing self-control and the ability to work and play with others. All Teachers are Special Education Teachers specifically trained to work with students diagnosed with autism spectrum disorders
- All teachers are trained in non violent crisis intervention.

All Children are encouraged to:

- Cooperate with staff and other children.
- Respect self, others and property
- If needed, a quiet area will be available.
- In any instance when a camper does not abide by the camp rules, is disruptive, violent or a poses a threat to the safety of the camp, students and/or staff, the camp director reserves the right to contact parent or guardian and remove the child for the camp for the day. Camp fees will not be refunded.

Participants full name: _____

Parent or Legal Guardian's initials: _____



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MEDICATION AUTHORIZATION:

In order for medication to be administered by staff, medication must be brought in its original container with clearly written directions for usage and current date. Parent/Guardian must also fill out Medication Authorization Form.

PHYSICIAN INFORMATION:

Name of Primary Physician	Address	Phone
Name of Physician/Specialist	Address	Phone
Name of Dentist	Address	Phone

EMERGENCY INFORMATION:

If we cannot locate a parent in an emergency, please list two people that we can contact that can authorize any emergency treatment for your child. Insurance information helps facilitate the billing in your absence. Please provide us with your Insurance information in the event of an emergency.

Authorized Name	Relationship	Daytime Phone Number/Cell Phone Number
Authorized Name	Relationship	Daytime Phone Number/Cell Phone Number
Name of Person with Insurance Benefit	Name of Insurance Provider	Policy Number

ALLERGIES, MEDICATIONS & ILLNESSES:

Dietary restrictions, allergies, medications and chronic illnesses must be disclosed on application so that our staff is aware of them.

Dietary Restrictions: _____
 Allergic to: _____
 Medications: _____
 Dosage/Schedule: _____
 Reason for Medication: _____
 Prescribing Physician or OTC: _____
 Chronic Illness: _____
 Disabilities or Other Conditions: _____
 Special Notes or Considerations: _____

In the event of any emergency, I authorize contact with and release of Physician and Emergency Information and authorized treatment from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for my ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF PARTICIPANT NAMED BELOW; I HAVE READ AND FULLY UNDERSTAND THE CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR EMERGENCY MEDICAL TREATMENT, AND DO HEREBY CONSENT VOLUNTARILY AND WITHOUT RESERVATION TO ALL ACTIVITIES PROVIDED FOR HEREIN.

Participants Full Name: _____

Signature of Parent or Legal Guardian: _____ Date: _____



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Summer Camp
2009**

EMERGENCY RESPONSE INFORMATION:

Name of Participant: _____

Emergency Contact Name/Phone No.: _____

Is the child able to communicate with speech: _____

Does the child understand receptive language (what is said to him/her)? Yes or No: _____

In not, describer his/her method of communication: _____

Would the child be able to communicate his name, address, and telephone number in high stress situation? _____

Does the child engage in any unusual behaviors that might seem disrespectful or threatening (i.e, yelling, giggling, standing too close to people)? If so, please describe.: _____

In a high-anxiety situation, how would the child most likely communicate? _____

Is the child prone to respond in an unusual manner to sensory input (sounds, lights, smells, etc)? Yes/No: _____

Circle what may result: seizure panic flight fight withdrawal other (please describe) _____

What might trigger what is circled above: _____

Does the child have specific fascinations (i.e., tree climbing, water)? If so, please describe: _____

Does the child have an accurate sense of danger? _____

Does the child have any other medical conditions or is she/he taking any medications? If so, please describe: _____

Please describe anything that might be helpful to emergency personnel (police, fire, EMT): _____

In the event of any emergency, I authorize contact with and release of Physician and Emergency Information and authorize treatment from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for my ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF PARTICIPANT NAME BELOW; I HAVE READ AND FULLY UNDERSTAND THE CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR EMERGENCY MEDICAL TREATMENT AND DO HEREBY CONSENT VOLUNTARILY AND WITHOUT RESERVATION TO ALL ACTIVITIES PROVIDED FOR HEREIN.

Participant's Full Name: _____ Signature of Parent or Legal Guardian: _____



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WAIVER & RELEASE OF CLAIMS:

It is expressly agreed that all use of the City of Independence, equipment and services, and participation in, or a spectator to, any programs conducted within or on the property of the City of Independence in conjunction with The Autism Society of Greater Cleveland including its board members, employees, independent contractors, teachers and student aides shall be undertaken by me, or my child, or my legal ward at my/his/her sole risk, and the City of Independence, The Autism Society of Greater Cleveland, its board members, employees, independent contractors, teachers and student aides shall not be liable for injuries or any damages to me, or my child, or my legal ward, or to any of my property, or my child's property, or my legal ward's property, or to be subject to any claim, demand, injury or damages whatsoever, including, without any limitation, those injuries and/or damages resulting from acts of active or passive negligence on the part of the City of Independence, their employees, agents, representatives, officials, or Board Members in conjunction with The Autism Society of Greater Cleveland, its board members, employees, independent contractors, teachers and student aides. I, for myself and on behalf of my children, my executors, administrators, legal wards, heirs, assigns and successors, do hereby expressly forever release discharge the City of Independence, their employees, officials, agents, board members, assigns and or successors, The Autism Society of Greater Cleveland, including its board members, employees, independent contractors, teachers and student aides assigns and or successors from all such claims, demands, injuries, damages, actions or cause of actions whatsoever.

The undersigned further expressly agree(s) that the foregoing WAIVER & RELEASE OF CLAIMS is intended to be as broad and inclusive as permitted by the laws of the State of Ohio, shall survive the observation, use or participation of the facilities, programs vehicles and equipment by the child/person attending listed below, and that if any provision of this release form, or portion thereof, is held invalid or unenforceable, it is agreed that the balance shall continue in full force and effect.

I certify that I am the parent or legal guardian of the attending child/person named below; that I have read and fully understand this Waiver & Release of Claims, and do hereby consent voluntarily and without reservation to its terms.

Signature of Parent/Guardian

Print Name of Parent/Guardian

Print Name of Child Attending ASGC Social Skills Summer Camp 2009

T- Shirt Size of Child: _____

**Mail Completed Forms, IEP & MFE with \$250 (Check Payable to ASGC) Fee to:
ASGC, P.O. Box 41066, Brecksville, OH 44141**