The Arc of the St. Johns
Summer Program

Phone 904.824.7249 Ext. 124; Fax 904.824.8063
lbolt@arcsj.org

We are excited to offer you a summer program for your child!

Listed are a few topics that we want you to be aware of for your child to attend our program this summer:

1. Each child will need to bring a morning snack/drink, and lunch each day. If they are in extended day, an afternoon snack will also be needed. If there are special needs in regards to food intake i.e. need food chopped, etc., please document this on the form in the enrollment packet.
2. ENROLLMENT PACKET MUST BE TURNED IN BEFORE THE CAMP STARTS. No child will be admitted to the summer program without a completed packet.
3. If you are interested in your child attending any of these weeks, please check the week you would like them to attend so we can plan for adequate staff coverage.

   ___June 6-June 10
   ___June 13-June 17
   ___June 20-June 24
   ___June 27-July 1
   ___July 5-July 8 (no camp July 4)
   ___July 11-July 15
   ___July 18-July 22
   ___July 25- July 29

   Please put your Ins. Co. and policy # on the medical page of the enrollment packet .
4. **Please attach copies of IEP's or Behavior Plans to ensure continuity of care**
5. If you have any questions that I have not addressed in this cover letter, please do not hesitate to ask! Office # 904.824.7249 Ext. 124

Sincerely,
Lori Bolt, BCBA

ENROLLMENT PACKET

Date of enrollment _____ Date _____

Child's full name _____ DOB_____

Address _____ SS #_____

City _____ State _____ Zip _____ Phone #_____

Full Name of Mother _____

Address of Mother _____

City _____ State _____ Zip _____ Phone#_____

Work Address_____ Work phone _____

Cell phone _____

Full Name of Father _____

Address of Father _____

City _____ State _____ Zip _____ Phone #_____

Work address _____ Work phone _____

Cell phone _____

Name: _____

EMERGENCY INFORMATION:

Name (s) of person (s) other than parent/guardian who have permission to take child from the facility:

_____

_____

Name and phone number of at least one person other than parent/guardian to contact in case of emergency:

_____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

List any known allergies _____

_____

Is your child currently taking any medication? _____ Yes _____ No

Current Medications:
Physician's Name:_____

Medication Name	Dose	Reason

NOTE: ALL medications, prescription and non-prescription that are to be disbursed during camp hours, MUST be in their ORIGINAL containers (duplicates can be obtained at your pharmacy). Original and unaltered pharmacy labels must be affixed to and clearly printed on the prescription medications. Medications that do not match these criteria will NOT be accepted.

Name _____

Does your child have a diagnosis? _____

Does your child have seizures? _____ Yes _____ No

Please describe the type and appearance of the seizures_____

_____

Frequency of occurrence _____

When was the last seizure? _____

Does your child have any behavioral problems? Please List (hitting, biting, screaming, etc.)

_____

_____

Does your child have any special habits or fears (noise, bugs, dogs, etc.)?

_____

_____

_____

Special Equipment: Check all that will be brought to the camp

- ☐ Wheelchair
- ☐ Eye glasses
- ☐ Walker
- ☐ Hearing aid
- ☐ Crutches
- ☐ Other adaptive equipment _____

Communication Abilities:

How does your child communicate: (check all that apply)

- ☐ Verbally
- ☐ Sign Language
- ☐ AAC Device
- ☐ Other Electronic Device _____
- ☐ Pictures
- ☐ Gestures

Eating Habits:

Allergies to Food? Yes/No, If Yes, what_____

Does your child require special feedings (i.e. g-tube)? Yes / No

Does your child have special dietary needs: What are they?

_____

_____

Toileting Habits:

Is your child toilet trained? Yes / No
How often does he/she need to toilet? (every 2 hours, etc.)? _____

Does your child wear diapers? Yes / No

Does your child need assistance during toileting? Yes / No

Name_____

PERMISSION TO PHOTOGRAPH

I, _____, hereby authorize the The Arc of the St. Johns Inc. permission to release photographs of my child for program activities and publicity.

_____ _____

Date Signature of parent/guardian

Name_____

MEDICAL POLICIES

In order to ensure health the health and safety of our students and staff, the following procedures will be followed.

1. Parents/guardians are required to notify the Director within 24 hours of a diagnosis of a communicable disease.
2. When the school is informed that a student has been diagnosed with a communicable disease, parents/guardians will be notified within 24 hours.
3. When prescribed an antibiotic, the student must be on antibiotics for 24 hours before returning to school.
4. The student must be free of fever, vomiting, or diarrhea for 24 hours before returning to school. Students experiencing any of these symptoms will be sent home from school.
5. Your child's mucus must be clear. Discolored mucus is a sign of illness and the student will be sent home.

_____ _____

Date Parent/guardian signature

CONSENT FOR EMERGENCY MEDICAL ATTENTION

Child's Name: _____ SS# _____

(SS# is mandatory for St. Johns County Emergency Response Service to be able to transport your child to the hospital in an emergency. This form will be kept in our office)

I hereby give staff of The Arc of the St. Johns permission to see that emergency medical treatment is given in the situation that such is required and I am not available for the consent at the time. Emergency medical treatment will be obtained at the nearest hospital.

911 will be called in any medical emergency that requires more than just basic first aid treatment.

If your child has a specific medical condition that requires a Physicians' Medical Plan, please provide a copy to the school.

Consent to dispense any medication must be submitted in writing to the school.

Primary name on Ins. Policy _____

Insurance company name:_____ Policy # _____

Medical Group: _____Telephone Number: _____

_____ _____

Date Parent/guardian signature

Excursion & Transportation Consent

I, _____, the parent/guardian, hereby give permission to The ARC of the St. John's Summer Camp, for my child _____ for the following:

To participate in excursions involving transportation provided by the ARC of the St. John's to locations such as (but not limited to) libraries, parks, pools, schools, playgrounds, museums and pet stores. **For days of transportation off grounds you will provide the ARC of the St. John's Summer Camp with the necessary Safety Seat/Device that will allow your child to travel safely and comfortably**. All parents will be notified in advance of any off campus excursions. Please Circle below whether your consent is given or if you do not give consent:

_____**I DO** give consent for my child to participate in excursions involving ARC Summer Camp transportation.

_____**I DO NOT** give consent for my child to participate in excursions involving ARC Summer Camp transportation.

I understand that if consent is not given that my child will not be able to attend any excursions and/or transportation. This form is valid from the above mentioned date until the date of termination.
With this signed agreement I (we) absolve the ARC of the St. John's Summer Camp of any responsibility for the safety, welfare, health, and well-being of the above named child, beyond such matters as may be called reasonable care for children in the custody of Camp staff.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

I, The ARC of the St. John's Summer Camp, the provider for the above mentioned child will transport the child to special trips. I will use safety seats/devices provided by the Parent/Guardian of _____ when necessary and with good judgment. This form is valid from the above mentioned date until termination.