



**Move, Think, Create, Communicate**  
**Summer Camp Registration 2010**  
 August 9-13 and August 16-20, 2010

<b>Camper's Name:</b>		<b>DOB:</b>		<b>Age:</b>	
T-Shirt Size Youth: <input type="checkbox"/> XS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL		Adult: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL			
Name(s) of Parent(s)/Caregiver(s):					
Address:		City:		State:	Zip:
Home Phone:		Cell Phone:		Email:	
Party responsible for payment: <input type="checkbox"/> Parent <input type="checkbox"/> School If school,					
Name(s) of person to whom camp information should be sent:					
Address:		City:		State:	Zip:
Office Phone:		Email:			
<b>Camper Information</b>					
Diagnoses: <input type="checkbox"/> High Functioning Autism <input type="checkbox"/> Asperger Syndrome <input type="checkbox"/> Autism <input type="checkbox"/> PDD NOS <input type="checkbox"/> Communication Disorder (please specify) _____					
Additional related diagnoses:					
<input type="checkbox"/> New Participant			<input type="checkbox"/> Returning Participant		
CEDARR Center: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?					
Does your child receive HBTS services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?					
Does your child receive PASS services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?					
<p><b>Camp Cost:</b> \$400.00 for the week <i>plus</i> \$75.00 non-refundable deposit (Total = \$475.00)  <i>(Please note, RI Medical Assistance - Katie Beckett, Rite Care, SSI - does not pay for camp.)</i></p> <p>Please complete the "Payment Information" portion of this application to indicate how the payment will be made (page 11). There are a limited number of Camperships available based on a sliding scale. You may request an application which you will submit with a copy of your W2(s). Please call Jill Norwood at 401-785-2666, ext., 1011 to request the Campership application.</p> <p><b>Please Note:</b> <i>All camp groups and times will be determined according to the attached "Summer Camp Deadline Schedule." Due to the number of applicants, the session dates cannot be chosen by families, but will be determined based on children's ages and abilities. Thank you for understanding.</i></p>					

**The Autism Project Summer Camp 2010  
CAMPER PROFILE**

<b>Camper's Name</b>	<b>DOB</b>	<b>Date</b>	
<i>Please complete the following sections and provide as much detail as possible. This information will help us create a successful experience for your child.</i>			
Please check all items that apply to child's present health. Thoroughly explain any checked answers.			
<b>Allergies</b> (list below): <input type="checkbox"/> No known allergies			
<input type="checkbox"/> Food (include any dietary restrictions):			
<input type="checkbox"/> Insects/Plants:			
<input type="checkbox"/> Medicine Allergies:			
<b>Treatment</b> for any of the above that The Autism Project may need to perform.			
<input type="checkbox"/> Epi Pen <b>**Doctor's order required**</b>			
<input type="checkbox"/> Other:			
<b>Medications</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, please list the medications below, Please indicate if a medication must be administered at camp. If yes, a doctor's order is required.			
<input type="checkbox"/> Admin at camp	Time:		
<input type="checkbox"/> Admin at camp	Time:		
<input type="checkbox"/> Admin at camp	Time:		
<b>Physical limitations:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, please explain:			
Recent history of hospitalization or other <b>important information for Camp Nurse</b> to know:			
<i>Please complete the following information in the event that an emergency arises and we must contact you. Include information about how to reach you or another designated person during your child's group.</i>			
<b>Emergency Contact Name</b>	<b>Relationship</b>	<b>Work Phone</b>	<b>Cell Phone</b>
<b>Emergency Medical Information</b>			
Name of Physician:		City:	Phone:
<i>In case of emergency, I understand that every effort will be made to contact me or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 911 protocol.</i>			
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			

<b>Camper's Name:</b>	
<b>Child's Likes:</b>	<b>Child's Dislikes:</b>
(favorite movies, characters, foods, games, music...etc) (sounds, smells, touch, movement, foods etc...)	
<b>Does your child use any of the following?</b>	
<input type="checkbox"/> Visual schedules	<input type="checkbox"/> Social Stories
<input type="checkbox"/> Choice Zone Worksheet	<input type="checkbox"/> Problem Solving Worksheets
<input type="checkbox"/> Thera-tubing	<input type="checkbox"/> Fidgets: _____
<input type="checkbox"/> Chewing Gum	<input type="checkbox"/> Brushing Protocol
<input type="checkbox"/> Relaxation Protocols: _____	<input type="checkbox"/> Weighted Blanket/Vest
<input type="checkbox"/> Other:	<input type="checkbox"/> Headphones: _____
	<input type="checkbox"/> Conversation Scripts
	<input type="checkbox"/> Contingency Mapping
	<input type="checkbox"/> Joint Compressions
<b>Please describe your child's skill level:</b>	
	Complete Assistance    Partial Assistance    Independent    Comments:
Toileting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dressing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Eating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>My child exhibits the following behaviors:</b>	
<input type="checkbox"/> Runs away	<input type="checkbox"/> Touches other inappropriately
<input type="checkbox"/> Scratches, bites or hits others	<input type="checkbox"/> Screams
	<input type="checkbox"/> Scratches, bites, hits self
	<input type="checkbox"/> Other:
<b>Does your child exhibit any of the following? If yes, please describe.</b>	
Self-regulation behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No    _____
Perseverative play or rituals?	<input type="checkbox"/> Yes <input type="checkbox"/> No    _____
Reaction to change?	<input type="checkbox"/> Yes <input type="checkbox"/> No    _____
How do you respond to these actions?	
When my child gets anxious she/he:	
When my child is excited she/he:	
When my child gets frustrated she/he:	

<b>Camper's Name:</b>				
<b>EMOTIONAL DEVELOPMENT</b>				
<b>Does your child:</b>	<b>Independent</b>	<b>With help</b>	<b>Not yet</b>	<b>Comments</b>
Request a break when upset?				
Express feelings?				
Indicate relaxation?				
Request assistance?				
Indicate likes/dislikes?				
Express confusion ("I don't know")				
<b>SOCIAL DEVELOPMENT</b>				
<b>Does your child:</b>	<b>Independent</b>	<b>With help</b>	<b>Not yet</b>	<b>Comments</b>
Engage in solitary play?				
Play same toy along side peers?				
Engage in group play?				
Share materials?				
Turn take with peers?				
<b>COMMUNICATION</b>				
<b>Does your child:</b>	<b>Independent</b>	<b>With help</b>	<b>Not yet</b>	<b>Comments</b>
Follow non-verbal directions?				
Follow verbal directions within familiar routines?				
Follow verbal directions within novel activities?				
Utilize visual supports to follow directions?				
Require processing time to follow directions?				
Use pictures/sign/ or other augmentative communication				
Comment on environment or the unexpected (oops!)?				
Make requests for basic wants and needs?				

<b>Camper's Name:</b>				
Call attention to others?				
Converse with peers/ adults?				
<b>ORGANIZATION &amp; TRANSITION</b>				
<b>Does your child:</b>	<b>Independent</b>	<b>With help</b>	<b>Not yet</b>	<b>Comments</b>
Make transitions?				
Recognize personal belongings?				
Organize needed materials for outings?				
Make choices?				
Wait when directed?				

Adapted from Kathleen Ann Quill's Assessment of Social and Communication Skills for Children with Autism

<p>Please describe your child socially. Include age of peers he/she enjoys; interests; games enjoyed; activities enjoyed; speaking style; etc.</p>
<p>Please describe your child's communication, including any strategies that are helpful to assist in your child's comprehension.</p>

<b>Camper's Name:</b>			
Rate the participant's behaviors from 1-10 (1= high difficulty, 10 = low difficulty)			
	<b>Home</b>	<b>School</b>	<b>Community</b>
Listens to others			
Organizes self and materials			
Problem solving			
Attentiveness to others			
Accepts responsibility			
Caring and affection			
Displays honesty			
Group participation			
Reads social cues			
Understands humor			
Regulates Emotions			
Shares materials			
Understands others' feelings			
Asks for assistance			
Converses with unfamiliar adults			
Stays on topic			
Argues with authority figures			
Comprehends rules			
Uses facial expressions			
Monitors own behaviors			
Please add any additional comments you feel staff should know and areas of concern or specific skills you are looking for us to be helpful in teaching your child.			



Dear Participant,

This is a survey we need you to complete once every year in order to report statistical and demographic information for a United Way grant that supports this program and to fulfill data requirements for future grant opportunities. Please take a few minutes to fill out the survey below. No names are required and all information will be kept strictly confidential. Thank You!

## Direct Service Programs Demographic Survey

### Participant's Information

Sex of participant  Male  Female

Participant's Age: \_\_\_\_

Participant's Primary Language  English  Spanish  Portuguese  Non-verbal

### Primary Diagnosis

Autism  Asperger Syndrome  Childhood Disintegrative Disorder  
 High Functioning Autism  Fragile X  Rett's Syndrome Disorder  PDD-NOS  
 PDD-NOS  Non-Verbal Learning Disorder

### Family's Information

Number of people living in the household \_\_\_\_

Annual Income:  \$0-20,000  \$10,000-25,000  \$26,000-50,000  \$51,000+

### Nationality

African  African American/Black  Asian  Asian American/Pacific Islander  
 Cape Verdean  Caribbean  Caucasian/White (non-Hispanic)  
 Hispanic/Latino  Native American  Portuguese  Multi-Racial/Multi-Ethnic  
 Other (please specify): \_\_\_\_\_  Information Not Available

Primary Language  English  Spanish  Portuguese  Other: \_\_\_\_\_



## Social Skills / Camp Programs PERMISSION TO PHOTOGRAPH

Participant:	DOB:
<p>Thank you for your interest in the Autism Project's social skills program. We are always striving to provide the best in innovative and meaningful programs designed for children with autism spectrum disorders, and to provide the highest quality support and education for parents and professionals. In this spirit, we are pleased to be able to be a training site for students and professionals throughout our community.</p> <p>To ensure a productive and enjoyable experience for both students and educators, we are adopting an OPEN PICTURES POLICY. Children attending groups and camp may have their pictures taken throughout the day. In addition to using photos and videos for training purposes, please be advised that photos may be used for program development and marketing purposes, including but not limited to newspaper articles, television promotion, brochures, and other Autism Project advertising vehicles.</p> <p>Thank you for your cooperation with this policy and willingness to share your child's experiences.</p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills / Camp Programs PERMISSION FOR RESTRICTIVE PROCEDURES

Participant:	DOB:
<p>The Autism Project uses evidenced-based strategies that are designed to establish a supportive and safe environment that will prevent your child from having behavioral difficulties. However, there may be rare occasions when the physical safety of the child, other participants, and staff is at risk. When this type of incident occurs it may be necessary to physically hold your child to prevent harm, and to help her/him feel safe. Trained staff will only use a therapeutic hold in which your child is seated in a chair or on the floor and held in a "wrap" from behind. The hold is only maintained for as long as it takes for your child to begin to regain emotional and physical control so that s/he can move to a quieter area until they are able to rejoin the group. If it is necessary to move your child to a safe area before s/he has regained control, two staff will use an approved escort procedure. These procedures are carried out in a calming, supportive, and non-punitive manner. You will be notified when you pick up your child of the intervention so that you can assist staff in processing the incident and supporting your child.</p>	
<p><i>I understand that the above procedures will be implemented only for the purpose of safety and control and in accordance with the stated guidelines. I authorize that the seated wrap or two person escort will not compromise the medical safety of my child.</i></p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills / Camp Programs PERMISSION TO PICK UP CHILD

Child:	DOB:		
Parent:	Date:		
Address:	Phone:		
<p>Please complete the following information in the event that someone other than yourself may pick up your child from a social skills group. You must notify us in advance of who will be picking up your child. Please note that we may ask that person to present identification to verify their identity before releasing your child to her/him</p>			
Name	Address	Relationship	Phone #
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			



## Summer Camp Program

### PAYMENT INFORMATION (Confidential)

<b>Camper Name:</b>		
<b>Parent Name:</b>		
<b>Billing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Method of payment for Registration Fee (\$75.00)</b>		
<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover		
For Credit cards, Card #		Exp. Date:
Cardholder's Name:		
Cardholder's Billing Address:		
<b>Method of payment for Camp Tuition (\$400.00) (Will not be processed until the first week of camp)</b>		
<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover <input type="checkbox"/> Purchase Order from School		
For Credit cards, Card #		Exp. Date:
Cardholder's Name:		
Cardholder's Address:		
<i>I authorize The Autism Project to process my payment as indicated above.</i>		
Parent/Guardian Signature:		Date:

<input type="checkbox"/> Campership Program A limited number of Camperships are available based on need. A scholarship application must be requested & submitted with verification of family income (W2, tax return, etc).
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<b>FOR OFFICE USE ONLY</b>		
Payment Received: ____ / ____ / ____ \$ ____	Initials: _____	Campership award: _____
		Parent Portion: _____



**\* SUMMER CAMP DEADLINE INFORMATION\***  
**Please keep this page for future reference**

- JUNE 1, 2010**      **DEADLINE FOR ALL CAMP REGISTRATIONS**
- JUNE 15, 2010**    **LETTERS CONFIRMING PLACEMENT MAILED**
- JUNE 30, 2010**    **TOTAL CAMP PAYMENT DUE**
- JULY 1, 2010**      **WAIT LIST CALL BACKS**

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**AUGUST 9-13, 2010**  
**CAMP SESSION ONE**

**AUGUST 16-20, 2010**  
**CAMP SESSION TWO**

**Registrations that are received after the above deadline or without the \$75.00 registration fee will result in your child being placed on a wait-list for an appropriate opening based on age and ability. We appreciate your understanding.**

**Please mail the registration packet to:**  
**The Autism Project**  
**Attention: Jill Norwood**  
**1516 Atwood Ave.**  
**Johnston, RI 02919**

**Or e-mail it to Jill Norwood, Administrative Assistant:**  
**[jill@theautismproject.org](mailto:jill@theautismproject.org)**

**The Autism Project Summer Camp**  
**Held at Camp Champlin, 223 Scituate Ave. Cranston, RI**