ASDB TRANSITION CAMP
CAMPERS APPLICATION CHECKLIST

1200 W. Speedway Blvd., TUCSON AZ 85745

ASDB'S SUMMER TRANSITION CAMP IS FOR ANY DEAF, HARD OF HEARING, AND DEAF-BLIND ARIZONA TEENS, AGES 13-17 YEARS OLD. PLEASE ENSURE THAT ALL THE ITEMS BELOW ARE SUBMITTED PRIOR TO MAY 1, 2017 TO HOLD YOUR CHILD'S PLACE IN CAMP. REGISTRATION WILL NOT BE ACCEPTED/COMPLETE IF THESE ITEMS ARE NOT FULLY COMPLETED AND SUBMITTED.

REGISTRATION CHECKLIST

- ✓ REGISTRATION FORM
- ✓ PHYSICAL EXAMINATION FORM & MEDICATION LOG (FILLED OUT BY CAMPER'S DOCTOR)
- ✓ COPY OF CAMPER'S STUDENT ID
- ✓ COPY OF CAMPER'S MEDICAL INSURANCE CARD
- ✓ $175 REGISTRATION FEE
    - (CHECK OR MONEY ORDER PAYABLE TO "ASDB" FOR TRANSITION CAMP)

SEND ALL DOCUMENTS TO JENNIFER HENSLEY BY **MAY 1, 2017**:

ARIZONA STATE SCHOOLS FOR THE DEAF AND THE BLIND
C/O JENNIFER HENSLEY, DIRECTOR OF DEAF PROGRAMS
800 W. WASHINGTON ST. SUITE 539
PHOENIX, AZ 85042

ARRIVAL – CAMPERS SHOULD BE DROPPED OFF AT THE ASDB GYMNASIUM AT 3PM ON SUNDAY, JUNE 11, 2017. IF YOU ARRIVE EARLY, YOU WILL HAVE TO WAIT IN THE LOBBY WITH YOUR CHILD AS STAFF WILL BE IN TRAINING UNTIL 3PM.

DEPARTURE – ON THE LAST DAY OF CAMP, JUNE 23, 2017, WE WELCOME PARENTS/ GUARDIANS TO JOIN US FOR A 1-3PM WORKSHOP AND FROM THERE YOU WILL PICK UP CAMPERS WHO ARE FREE TO JOIN YOU AFTER 3PM. CAMPERS ARE TO DEPART NO LATER THAN 5PM.

SEND QUESTIONS OR COMMENTS ALONG TO JENNIFER HENSLEY, JENNIFER.HENSLEY@ASDB.AZ.GOV, 602-771-5255 (VOICE) OR 602-551-8582 (VIDEO PHONE).

THERE WILL BE PRE-ARRANGED PICK UP/DROP OFF TRANSPORTATION PROVIDED IN VARIOUS LOCATIONS AROUND ARIZONA IF NEEDED. INDICATE THE PREFERRED REGION ON THE REGISTRATION FORM TO SIGN UP & ADDITIONAL INFORMATION ABOUT THE TIME AND LOCATION WILL BE SENT AT A LATER DATE.

ASDB TRANSITION CAMP
CAMPERS APPLICATION

1200 W. Speedway Blvd., TUCSON AZ 85745

____

NAME OF CAMPER (LAST, FIRST, MIDDLE)   PREFERRED NAME

____

STREET ADDRESS   CITY   STATE, ZIP

DATE OF BIRTH _____________________ SCHOOL ATTENDS ____________________________

GENDER: MALE _____ FEMALE ____   GRADE (FALL 2017) ____

T-SHIRT SIZE – (ADULT SIZE – CIRCLE ONE)   XS   S   M   L   XL   2XL   3XL

HOME PHONE/VIDEOPHONE _______________________________________

EMAIL ADDRESS _______________________________

HOW DID YOU LEARN ABOUT US?

PARENT/GUARDIAN INFORMATION

____

NAME OF PARENT(S) /GUARDIAN

____

STREET ADDRESS   CITY   STATE, ZIP

____

AREA CODE   DAY PHONE   EVENING PHONE

AUTHORIZED PERSON TO SIGN OUT CAMPER, IF DIFFERENT FROM PARENT/GUARDIAN

_____________________________________ _______________________________________

NAME   PHONE/EMAIL/VP

EMERGENCY CONTACT (1)

____

NAME   RELATIONSHIP

____

AREA CODE   DAY PHONE   EVENING PHONE

____

ADDRESS   (CITY)   (STATE) (ZIP)

EMERGENCY CONTACT (2)

____

NAME   RELATIONSHIP

AREA CODE   DAY PHONE   EVENING PHONE

____

ADDRESS   (CITY)   (STATE) (ZIP)

GENERAL INFORMATION

Has the camper ever attended camp before? ____Yes ____ No
If Yes, Name of Camp(s):

Please Describe the Camper's Swimming Ability (None/Beginner, Intermediate, Advanced):

Briefly describe the camper's experience with transition (i.e. works with a vocational counselor, works with parents on independent skills, attends a vocational program, etc.):

Additional Information about the camper that we should be aware:

Camper's primary language: ASL, English, Spanish

Camper's secondary language: ASL, English, Spanish

Camper's preferred mode of communication: ASL, Spoken English, Sign supported speech

Does the camper use assistive technology (i.e. hearing aids, CI or Baha)? ____Yes____ No
Does the use of the device(s) limit or restrict the camper's activities? If yes, please describe:

TRANSPORTATION

There will be drop off/pick up locations around Arizona for parents/guardians that are unable to provide transportation for campers to/from ASDB's Tucson campus. In preparation for scheduling transport to remote sites, please indicate which region you would like to drop off and/or pick up your child:

Drop off (June 11, 2017)	**Pick up (June 23, 2017)**
Flagstaff	Flagstaff
Phoenix	Phoenix
Yuma	Yuma

Note: You will be contacted with specific drop off/pick up times once they are finalized.

PARENT/GUARDIAN CONSENT

Print Camper Name____________________ Print Parent/Guardian Name__________________

AUTHORIZATION FOR EMERGENCY MEDICAL CARE (PLEASE ATTACH MEDICAL INSURANCE CARD)
I/We hereby give my permission to ASDB Transition Camp to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child (name) ____, should an emergency arise. It is understood that ASDB Transition Camp will make a conscientious effort to locate parents, and/or any emergency contact listed on this form before any action is taken. I/We will accept the expense of medical or surgical treatment.

____

Parent(s)/Legal Guardian Signature(s) & Date

NON-PRESCRIPTION MEDICATION

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

Acetaminophen (Tylenol)	**Ibuprofen (Advil, Motrin)**
Diphenhydramine antihistamine/allergy medicine (Benadryl)	**Sore throat spray**
Cough drops	**Calamine lotion**

MOVIE PERMISSION

I/We hereby give permission to watch movies during camp. She/he can watch (check all that apply):
'G' ___, 'PG'___, 'PG-13'___

____

Parent(s)/Legal Guardian Signature(s) & Date

CONSENT TO TAKING AND USE OF PHOTOGRAPHS

I/We hereby give my permission for photographs to be taken of our child during ASDB Transition Camp activities, and for publication (i.e. brochure, website, etc.) use reasonably related to the positive promotion of the ASDB Transition Camp programs.

____

Parent(s)/Legal Guardian Signature(s) & Date

AUTHORIZATION PARTICIPATE OR EXCLUDE PARTICIPATION IN ASDB TRANSITION CAMP'S ACTIVITIES

I/We hereby give my permission for my child to go on field trips away from ASDB Transition Camp's premises, whether on foot or by authorized vehicle with driver and a chaperone. I give permission for my child to participate in all ASDB Transition Camp's activities with the following exception(s) (Please indicate your exceptions(s).
I/We are making our exception on:

____

Parent(s)/Legal Guardian Signature(s) & Date

INDEMNINIFICATION (WAIVER'S) AGREEMENT

I/we agree to indemnify, hold harmless, and defend ASDB Transition Camp and their respective employees, agents, and representatives from and against any and all liabilities, claims or demands which may be asserted against any or all of them in connection with our camper's participation in ASDB Transition Camp. This includes holding ASDB Transition Camp harmless for any injury which may occur to our camper while traveling to the ASDB Transition Camp's facility, or while returning from the ASDB Transition Camp to go home.

____

Parent(s)/Legal Guardian Signature(s) & Date

Applicants Name	DOB	M: F:

Physician's Examination

HEALTH FORM

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in modified adaptive activities at camp. .

Height	Weight	Pulse	Blood Pressure	Hct/Hgb Test (If appropriate)	Urinalysis (If appropriate)

Please Rate the following:
V-Satisfactory
X-Not Satisfactory
O-Not examined

Eyes	Ears	Nose	Throat	Lungs	Heart	Abdomen	Genitalia	Hernia	Extremities	Posture	Skin	Neuro
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Hearing
Please check one

Right Ear ☐ Left Ear ☐

Vision
Please check one

Totally Blind ☐ Legally Blind ☐ Low Vision ☐

General Appraisal
Please address any concerns from above.

Allergies
Please list any known allergies and the applicant's reaction to allergen.

Immunizations

Date of last Tetanus Shot

Are immunizations up to date? **Yes:** ☐ **No:** ☐

Current Medical Problems and Treatments
Please attach additional pages if necessary.

Primary Disability

Secondary Disability

Applicants Name	DOB	M: F:

Seizures
Please include seizure type, typical length and frequency, and any known triggers or seizure specific care instructions.

Cardiovascular
Arrhythmias, hypertension, pacemaker, oxygen, etc.

Neuromuscular
Paralysis or loss of muscle function.

Recommendations
List any restrictions of the applicant at camp.

Other Concerns/ Additional Comments
Feeding tube, feeding frequency, ostomy, suctioning, or other necessary assistive

Patient is cleared for 7,000 ft. elevation? **Yes** ☐ **No** ☐

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

I examined the applicant today **Yes** ☐ **No** ☐

	If no, date of examination
Name of Doctor	Signature
Contact Information	Date

Camper's Medication Log

Medication Log: *Please fill out and return both forms fully completed with Physicians signature.* ***ANY OVC MEDICATIONS DEEMED NECESSARY BY THE PHYSICIAN MUST BE LISTED ON THIS MEDICATION LOG OR THEY WILL NOT BE GIVEN.***

Applicants Full Name	Birthdate

Medications (mg)	Amount Given	Times Given *(Please specify)*	Special Instructions

Doctors Name	Signature
Contact Info	

Camper's Medication Log

HEALTH FORM

ASDB

Medication Log: *Please fill out and return both forms fully completed with Physicians signature.* ***ANY OVC MEDICATIONS DEEMED NECESSARY BY THE PHYSICIAN MUST BE LISTED ON THIS MEDICATION LOG OR THEY WILL NOT BE GIVEN.***

Applicants Full Name	Birthdate

Medications (mg)	Amount Given	Times Given *(Please specify)*	Special Instructions

Doctors Name	Signature
Contact Info	