CAMP CIVITAN
Promoting Lifelong Fun Adventures for the Developmentally Disabled Since 1968

Camp Civitan 2010 Main Summer Programs

The Civitan Foundation is a non-profit organization dedicated to individuals with Developmental Disabilities since 1968. Camp Civitan is our longest running program offering overnight camping experiences in Williams Arizona. **The Civitan Foundation is a qualified vendor with DDD/DES and is able to accept respite for camping experiences.** We pride ourselves on the fact that each year we have many returning happy campers. Camp is designed to foster of peer socialization, educational programs, life skills, physical activities, gross and fine motor skills, teamwork, healthy living, food and nutrition, and lots of fun. Each session has a theme and includes some type of field trip. Other activities include guest speakers from the local communities, arts, crafts, fishing, hiking, and swimming, just to name a few. *Activities are all subject to availability, weather, and circumstances beyond our control. Sessions do sellout; please confirm your desired space ASAP.

The Civitan Foundation Inc. is pleased to announce our 2010 camping schedule. We will DEPART on MONDAYS AND RETURN ON MONDAYS. Why? A Monday departure and return will give you, the parents and caregivers, not only a whole week of respite, but a full weekend as well. This will also enable us to attend and participate in many of the festivals and community events in Northern Arizona. Camp will be 7 nights: Monday to Monday. Each week requires a $50 activity fee; this is used for field trips, arts and crafts, off camp activities, and meals. We contract a charter bus company for weekly transportation, this is available on a first-come basis, and wheelchairs space is limited. All applications must be completed in full and accompanied by a $50.00 deposit. Once the applications are received, they will be processed and intake interviews will be scheduled for all new applicants.

Camp Application Instructions:

1. Parent and/or guardian must complete the entire application; leaving no blank spaces. Medical forms and releases must accompany application. All campers, returning or new MUST COMPLETE all forms.
2. If using respite, authorizations for respite hours, **MUST** be approved and authorized by support coordinators **before** camp session.

Camp Session Fees: Private Pay fees are $745.00 per session plus a $50 activity fee and transportation costs.

1:1 Supervision will have an added fee of $200 per week or $100 per weekend (private pay or respite). Decisions regarding 1:1 supervision are determined before camp during the applicant's intake interview.

1. Payments and completed applications must be received no later than 3 weeks prior to the start of the camping session.
2. There will be an additional $50 late filing fee for any registrations received after that date.
3. Full refunds will only be issued for cancellations made 2 weeks prior to the reserved camping session(s).
4. A partial refund of half of the amount paid will only be issued for cancellation during the 2 weeks prior to the reserved session(s).
5. No refund will be issued for last minute cancellations
6. No refunds will be issued for any clients who are sent home due to illness, behavior, or homesickness.

Registration/Deposits:

Make checks payable to: **The Civitan Foundation, Inc.** **Mail to: 3509 E Shea Blvd., #117 Phoenix, AZ 85028**

All correspondence should be done with the main office using the following methods:

Phone: (602) 953-2944 • Fax: (602)953-2946 • E-mail: info@campcivitan.org

MEDICATIONS: Applicants will not be allowed to attend camp unless: all medications, including vitamins are sent to camp **in daily pill binders (for all doses) breakfast, lunch, dinner, and bedtime…etc. accompanied by their original prescription bottles, and placed in a Ziploc bag labeled with the camper's name and brought to check in.** All medications must be listed on the medical form and approved by a physician. This policy will be enforced and campers will not be able to board the bus if not received this way. Please call our office if you have any questions regarding our policy.

Transportation: Charter bus transportation is available for $60.00 round-trip per person. This service is limited and fills up quickly. Please indicate on page 2 if transportation is desired.

The bus will leave the Phoenix office (3519 E Shea Blvd. Ste 133) PROMPTLY AT 9AM

CHECK IN: PHOENIX 7:30-8:30AM MONDAY RETURN TIME: PHOENIX 4:00PM MONDAY

CHECK IN: WILLIAMS (CAMP CIVITAN) after 2:00PM PICK UP: WILLIAMS (CAMP CIVITAN) on or before 11:00AM

SCHOLARSHIPS: Need based financial assistance may be available, contact our office for more information.

CONFIRMATION: You will receive written or emailed confirmation approximately 2weeks prior to your scheduled camp session(s). **Please do not assume acceptance**.

Participant: _____ Date: _____

Please read and initial each and sign below.

I hereby give my consent for (camper's name)_____ to attend Civitan Foundation Programs**.**

Photos/Media: I grant permission to the Civitan Foundation, Inc. to use likeness, voice; and words of the participant in TV, newspaper, film/video, or other media, for the purpose of promoting Civitan Foundation, Inc. programs.

Please initial:_____

Search and Seizure: As a condition of participation and in order to provide a safe environment for all campers, Civitan Foundation enforces a policy of reasonable search and seizures of the person and or personal property in situations of suspected theft, illegal drugs, or possession of contraband items such as weapons, fireworks or alcohol. Your signature is deemed as written consent to such reasonable search and seizure and a waiver of all claims made against Civitan Foundation, Inc. **Please initial:**_____

Release: As a further condition to ensure the safety of all campers, I authorize Civitan Foundation, its agents, and employees, to call appropriate agencies, including Child Protection Services, law enforcement agencies, and mental health providers if (camper's name)_____ becomes violent or is threats to his/her own safety or the safety of others. **Please initial:**_____

Disclosure: I have fully disclosed (camper's full name)_____health conditions, including any propensities towards violent behavior. I authorize Camp Civitan to share this information with their counseling staff. **Please initial:**_____

Waiver of Responsibilities: The undersigned does hereby release and discharge Civitan Foundation, Inc. and any and all of its agents or affiliates, employees or volunteers from any and all claims, liabilities, demands or rights which I (we), or any friends or relatives, may have against said corporation, or any of its agents, affiliates, employees, or volunteers on account of, connected with, or growing out of, any injury, accident, loss, damage or suffering, I (we) may hereafter sustain while on the premises or property owned, leased, or used by Civitan Foundation, Inc., arising out of granting permission for camping and recreation programs or usage of the said premises, whether said property be known as Camp Civitan or any other named designation or location. I authorize the Civitan Foundation, Inc. staff to secure medical treatment if necessary in the event of an emergency. **Please initial:**_____

Off Camp Trips: I agree and consent that on occasion my camper may leave the Camp Civitan property if so authorized by the Director or persons in charge. **Please initial:**_____

Camp Civitan is a camp for a special population; however we are not equipped to service individuals who are medically fragile, with communicable diseases, or technologically dependent persons. Due to the nature of Camp Civitan, we are unable to accommodate individuals with psychological, emotional, and conduct disorders that are exhibiting aggressive tendencies. In making a final selection of clients, the Director reserves the right to take into consideration the needs of the applicant, other clients, and the expertise of the Staff. Each camping session will be balanced to best accommodate our clients' needs. The Camp Director, based on past experience or recent evaluation, may request that a personal attendant (supplied by the client) accompany any client for their stay at camp. This attendant must adhere to and follow all camp policies and meet with the Director prior to camp. Additional fees will be assessed and determined on a case by case basis.

Please initial:_____

Should it become necessary for my camper(s) to leave camp, or any Camp Civitan function, for any reason, I will make provisions to bring the camper(s) home. If the need arises to pick up my participant prior to the end of his camping session, I agree to promptly pick up my participant from camp. **Please initial:**_____

I hereby certify that to the best of my knowledge, all of the information contained in the application is true and complete.

Please initial:_____

I hereby authorize the release of any and all pertinent information regarding this camper to Camp Civitan.

Please initial:_____

I agree to notify Camp Civitan with any changes that need to be made in this application before camp.

Please initial:_____

I have read and understand the above statements. I agree to the Acceptance Conditions above.

Signature: _____Date: _____

Participant: _____ Date: _____

Household/Demographic Information: The household and demographic information is required for federal funding and reporting purposes only. This information provided will not affect eligibility for camp.

Total number of persons living in household:_____ Is applicant disabled? ☐Yes ☐No

Is applicant a female head of household ☐Yes ☐No Age of applicant _____ ☐Male ☐Female

Mark the number of persons living in your household and on the same line marked your total annual household income.
(Combined gross annual income of all persons in the house regardless of whether they assist with household expenses)
(Check off your income in one of these boxes)

Total No. of Persons Living in Household		Total Combined Household Annual Income		Total Combined Household Annual Income		Total Combined Household Annual Income		Total Combined Household Annual Income	
Check one		**Less Than Check one**		**Less Than Check one**		**Less Than Check one**		**MORE Than Check one**	
1		$12,150		$20,250		$32,400		$32,400	
2		$13,900		$23,150		$37,050		$37,050	
3		$15,650		$26,050		$41,700		$41,700	
4		$17,350		$28,950		$46,300		$46,300	
5		$18,750		$31,250		$50,000		$50,000	
6		$20,150		$33,600		$53,750		$53,750	
7		$21,550		$35,900		$57,450		$57,450	
8		$22,950		$38,200		$61,150		$61,150	
9		$24,300		$40,550		$64,850		$64,850	
10		$25,700		$42,850		$68,550		$68,550	

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaskan Native ☐Hawaiian Native/Pacific Islander

Are you Hispanic/Latino? ☐Yes ☐No (Includes Mexican, Cuban, Puerto Rican, Central & South American or other Spanish culture or origin regardless of race) Residence city: _____Zip Code_____

ACCEPTANCE CONDITIONS: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN YOUR NAME BELOW.

Camp Civitan does not discriminate on the basis of race, color, religion, sex or sexual orientation.

Camp Civitan reserves the right to refuse to provide services to any individual when the camp staff determines that the individual cannot be provided with adequate support by Camp Civitan. These decisions are made on an individual basis, by the Camp Director, or Executive Director. Parents, care-providers, and the DDD Support Coordinator (or other appropriate agencies) will be notified in the event of any serious injury or illness requiring more than basic first aid, or in the case of any significant incident or behavioral problem. The separate Medical History and Exam (Form B), signed by a physician must indicate that there is no evidence of any condition that might present health or safety risks to the applicant, or to other campers or staff members.

Signature_____ Relationship to Participant _____Date_____

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FORM A: Medical History and Exam
To Be Completed by Parent/Guardian

Participant: _____ Date: _____

Participant's Primary Disability/Diagnosis

☐ Autism	☐ Heart Condition	☐ Muscular Dystrophy
☐ Behavioral Disorder	☐ Learning Disability	☐ Spinal Bifida
☐ Cerebral Palsy	☐ Mental Illness	☐ Spinal Cord Injury
☐ Epilepsy	☐ Mental Retardation	☐ Stroke/Brain Injury
☐ Hearing Impairment	☐ Multiple Sclerosis	☐ Visual Impairment
☐ Other _____		

Check all that apply to the participant:

☐ Anemia	☐ Diarrhea	☐ High Fever	☐ Pneumonia
☐ Asthma	☐ False Teeth	☐ Immune Suppressed Disorder	☐ Polio
☐ Blood Clots	☐ Gall Bladder Problems	☐ Kidney Disorder	☐ Rheumatic Fever
☐ Cancer	☐ Gastritis	☐ Liver Disorder	☐ Spinal Bifida
☐ Chicken Pox	☐ Glasses	☐ Measles	☐ Substance Abuse/Addiction
☐ Chronic Bronchitis	☐ Head Trauma/Injury	☐ Meningitis	☐ Thyroid Disorder
☐ Chronic Ear Infections	☐ Hearing Aids	☐ Mental Illness	☐ Tuberculosis
☐ Chronic Nose Bleeds	☐ Heart Disease/Murmur	☐ Migraine Headaches	☐ Ulcers
☐ Constipation	☐ Hepatitis	☐ Mumps	☐ Valley Fever
☐ Diabetes	☐ High Blood Pressure	☐ Pacemaker	☐ Venereal Disease

Seizure History: Type: _____ Frequency: _____ Average Length: _____ Meds Prescribed: _____
Vagus Nerve Stimulator: _____ Last Seizure date: _____ Procedure to follow if seizure exceeds 3 mins.:_____
_____

Allergies ☐ Yes ☐ No If Yes, describe below:
Seasonal: Watery eyes, runny nose & congestion.
Procedures to follow if allergic reactions are detected: _____
Medication Allergies
Procedures to follow if allergic reactions are detected: _____
Food Allergies
Procedures to follow if allergic reactions are detected: _____
Other Allergies
Procedures to follow if allergic reactions are detected: _____

If participant must take medications, vitamins, or supplements while at camp, they MUST be listed on the Medication Administration Record and be reviewed by his/her physician. **All medications MUST be checked in before prior departure. Place all pill binders and original bottles in a Ziploc gallon bag with camper's name on it.** *I understand that medication times could be adjusted within 1 hour before or after the written times. *Seizure medication will be given as close to the directed time as possible.* **Please initial: _____**
If camper must take medication on the bus trip to camp, place that dose of medication in a separate sealed envelope or bag (with camper's name). Please be sure to advise staff at check-in.

Insurance Information (Copy of Insurance Card must be included with application)
Name of Insurance Co.: _____ Policy #: _____
Name of Policy Holder: _____ Relationship: _____
Copy of Insurance Card included ☐

Has camper spent a week away from a parent before? ☐ Yes ☐ No Comments: _____
_____
Has camper attended any other camp before? ☐ Yes ☐ No If yes, where? _____
Has camper been to Camp Civitan before? ☐ Yes ☐ No If yes, when (most recent date)? _____

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FORM A – Section 2: Medical History and Exam
To Be Completed by Parent/Guardian

Participant: _____ Date: _____

Special Instructions for Individual Needs (Please explain in detail.)

No	Yes	Client Name:
		Special Diet
		Mode of Communication
		Behaviors
		Falling
		Fears
		Aggression
		Wandering
		Food Allergies
		Seizures
		Sexually Active
		Self Stimulates
		Self Injures
		Sleep Habits
		Glasses/Hearing Aid
		Bed Wetting (If yes, please provide diapers/pull-ups & extra bedding.)
		Medication Times
		Life vest
		Swim Level ☐Non ☐Beginner ☐Intermediate ☐Advanced

Does camper wear diapers/pull-ups? Day ☐Yes ☐No **Night** ☐Yes ☐No
If so, please send enough for your camper's needs.

Independent	Assisted	Total Care	
			Eating
			Toileting
			Showering
			Dressing
			Shaving
			Menstrual Care (Must provide your own supplies.)
			Activities

I, the undersigned, hereby represent that I am the parent or legal guardian of this participant, and state the health history is correct to the best of my knowledge. I agree that he/she may participate in Civitan Foundation, Inc programs. I consent that in the event of sickness and accidents, Civitan Foundation Inc. will not be held liable. In the event I am unable to be reached, I authorize Civitan Foundation Inc. to seek necessary medical attention for _____in the event of an emergency. I agree to pay for any prescribed medication or treatment my participant may need.

Signature of Parent/Guardian _____ Date _____

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Medical Administration Record

PLEASE DO NOT MAIL THIS FORM!! IT MUST BE FILLED OUT AND BROUGHT WITH MEDICATION TO CHECK-IN

*You will not be able to board the bus until complete. Please list all medications (prescription & PRN's). All meds must be dosed out in daily pill containers labeled with times of dosage. You must also send original prescription bottles with at least 1 dosage.

Month	
Year	

Name:	Medication Allergies:	Food Allergies:	Cabin:	DOB:
			Bunk:	Age:
Special Instructions:				
Medical Diagnosis:				
Parent Signature:		Emergency number:		

Med./Dose/How Given/Freq.	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Rx❒																																
Med./Dose/How Given/Freq.	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Rx❒																																
Med./Dose/How Given/Freq.	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Rx❒																																
Med./Dose/How Given/Freq.	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Rx❒																																
Med./Dose/How Given/Freq.	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Rx❒																																

Initials	**Signature**	**Initials**	**Signature**

I understand that medication times could be adjusted within 1 hour before or after the written times. *Seizure medication will be given as close to the directed time as possible.

Parent Signature: ____ Date: ______________________ Emergency Phone: _____________________________