Camp Ausome Application (2019)

Campers must fulfill the following criteria in order to apply for Autism Nova Scotia- Cape Breton's Summer Camp 2019:

- Diagnosis of ASD (Autism Spectrum Disorder)
- Age 6-21
- At least one year of school completed before camp begins
- Participates in the camper intake process: parent questionnaires

Please note: All camp fees MUST be paid in full two weeks prior to your child attending camp.

*Required

Camper Information

Please fill out all the information below.

1. **FIRST Name** *
   First name of child

2. **LAST Name** *
   Last name of child

3. **Camper is new or returning to camp?** *
   Please select one
   Mark only one oval.
   - ◯ New to Summer Camp
   - ◯ Returning to Summer Camp

4. **Age of Child:** *
   Age of child in years

5. **Gender of Child:**

6. **Date of Birth:** *
   MM/DD/YYYY

7. **Camper lives:** *
   Please select one
   Mark only one oval.

   - ◯ Family home
   - ◯ Foster home
   - ◯ Residential home
   - ◯ Other

Mailing Address

8. **Street Address, Apartment number (if applicable):** *

9. **City/Town:** *

10. **Province:** *

11. **Postal Code:** *

Primary Guardian(s) Information

Please indicate who the camp confirmation package should be sent to.

12. **1. Parent/Guardian's Name:** *

13. **1. Relationship to Child:** *

14. **1. Home Number:**

15. **1. Work Number:**

16. **1. Cell Number:**

17. **1. Email:**

18. **1. This guardian is to be contacted for camp matters:**
Mark only one oval.

- Yes
- No

19. **1. This guardian is to be contacted for emergencies:**
Mark only one oval.

- Yes
- No

Secondary Guardian Information

20. **2. Parent/Guardian's Name:**

21. **2. Relationship to Child:**

22. **2. Home Number:**

23. **2. Work Number:**

24. **2. Cell Number:**

25. **2. Email:**

26. **2. This guardian is to be contacted for camp matters:**
Mark only one oval.

- Yes
- No

27. **2. This guardian is to be contacted for emergencies:**
Mark only one oval.

- Yes
- No

Emergency Contacts' Information

Emergency contacts if the camper's guardian(s) cannot be located

28. **First Emergency Contact Name:**

29. **3. Relationship to Child:**

30. **3. Home Number:**

31. **3. Work Number:**

32. **3. Cell Number:**

33. **Second Emergency Contact Name:**

34. **4. Relationship to Child:**

35. **4. Home Number:**

36. **4. Work Number:**

37. **4. Cell Number:**

Camp T-Shirt Size Order

Each camper will be given two camp shirts.

Youth T-Shirt Sizes:

Size	A	B	C
YX-SM	14"	18"	11.5"
YSM	16"	20.5"	13.5"
YMD	17"	22"	14.5"
YLG	18"	23.5"	15.5"
YXL	19"	25"	16.5"

Adult T-Shirt Sizes:

Size	A	B	C
SM	18"	27"	15.75"
MD	20"	28"	17"
LG	22"	29"	18.25"
XL	24"	30"	19.5"
2XL	26"	31"	20.75"

38. **T-Shirt Size:** *

Please choose a shirt size using the image and sizing charts above
Mark only one oval.

- Youth X-SM
- Youth SM
- Youth MD
- Youth LG
- Youth XL
- Adult SM
- Adult MD
- Adult LG
- Adult XL
- Adult 2XL

Health Information (Part One)

39. **Which diagnosis of ASD does your child have?** *
Mark only one oval.

- ◯ Autism
- ◯ Asperger's
- ◯ PDD-NOS
- ◯ Not sure
- ◯ No formal diagnosis

40. **Which professional gave your child the diagnosis?** *
Mark only one oval.

- ◯ Paediatrician
- ◯ Psychologist
- ◯ Psychiatrist
- ◯ Other

41. **Please provide the name of this professional:** *

_____

42. **Medical Health Card Number:** *

_____

43. **Family Doctor's Name:** *

_____

44. **Family Doctor's Phone Number:** *

_____

45. **Does your child require medication?** *
Mark only one oval.

- ◯ Yes *Skip to question 46.*
- ◯ No *Skip to question 59.*

Medication at Camp

If your child will need to be administered medication during camp hours please complete the following for all medications she/he/they will need.

46. **Will medication need to be administered during the summer camp program?** *

Mark only one oval.

- ◯ Yes
- ◯ No

47. **First Medication Name:**

_____

48. **First Medication Dosage:**

_____

49. **Time of day for the first medication to be administered:**

_____

50. **Second Medication Name:**

_____

51. **Second Medication Dosage:**

_____

52. **Time of day for the second medication to be administered:**

_____

53. **Third Medication Name:**

_____

54. **Third Medication Dosage:**

_____

55. **Time of day for the third medication to be administered:**

_____

56. **Fourth Medication Name:**

_____

57. **Fourth Medication Dosage:**

58. **Time of day for the fourth medication to be administered:**

Health Information (Part Two)

59. **Does your child have any medical conditions or mental health diagnosis staff should be aware of?** *
(e.g., asthma, stomach issues, depression, anxiety disorder, bipolar disorder, etc.)
Mark only one oval.

- Yes *Skip to question 60.*
- No *Skip to question 61.*

Medical or Mental Health

60. **If your child does have any medical or mental health conditions, please explain:**

Health Information (Part Three)

61. **Does your child have a history of seizures?** *
Mark only one oval.

- Yes *Skip to question 62.*
- No *Skip to question 67.*

Seizures

If your child has seizures please complete all the following questions.

62. **What type of seizures does your child have?**

63. **How frequently do they occur?**

64. **When was the last seizure?**

65. **How long do her/his/their seizures typically last?**

66. **What are the warning signs, if any?**

Health Information (Part Four)

67. **Does your child have any allergies?** *
Mark only one oval.

- Yes *Skip to question 68.*
- No *Skip to question 71.*

Allergies

68. **Please list any allergies your child has:**

69. **Are any of these allergies anaphylactic? If so, which ones?**

70. **Does your child carry an Epi-Pen?**
Mark only one oval.

- ◯ Yes
- ◯ No

Health Information (Part Five)

71. **Does your child have any nutritional needs?** *
Mark only one oval.

- ◯ Yes *Skip to question 72.*
- ◯ No *Skip to question 74.*

Nutritional Needs

72. **Please list any specific nutritional needs:**
(e.g., gluten free, lactose intolerant, etc)

_____

_____

_____

_____

_____

73. **Does your child have any particular eating habits or tastes?**

_____

_____

_____

_____

_____

Health Information (Part Six)

74. **Does your child use any assistive devices?** *
(e.g., wheelchair, iPod, Tango, etc.)
Mark only one oval.

- ◯ Yes *Skip to question 75.*
- ◯ No *Skip to question 76.*

Assistive Devices

75. **Please list any assistive devices your child uses:**

General Information

76. **Activities your child enjoys:** *
    Please provide a list below:

77. **Activities your child dislikes:** *
    Please provide a list below:

78. **Does your child have any worries/fears/anxieties?** *
    Please list below:

79. **What are your child's strengths?** *
Please list below:

Self Care

80. **Does your child have any issues around sleep?**

81. **Does your child go to the washroom independently?** *
(e.g., requires prompts, initiates on own, uses visual bathroom schedule, etc.) If no, please describe assistance required on the next page.
Mark only one oval.

- Yes *Skip to question 83.*
- No *Skip to question 82.*

Stop filling out this form.

Self Help Details - Washrooms

82. **Please list any washroom prompting/assistance required:**

Self Care (Part Two)

83. **Is your child able to dress/undress independently?** *

Mark only one oval.

- Yes *Skip to question 85.*
- No *Skip to question 84.*

Self Help Details - Dress/Undress

84. **Dress/Undress:**

Please list any assistance required:

Self Care (Part Three)

85. **Does the child require prompting to wash hands/face before eating?** *

Mark only one oval.

- Yes *Skip to question 86.*
- No *Skip to question 87.*

Self Help Details - Washing Hands/Face

86. **Wash Hands/Face Before Eating**

Please list any assistance required

Communication

87. **What current communication skills does your child have?**
(e.g., verbal, vocalizations, words, sign language, PECS, etc.)

88. **Is your child able to communicate their needs effectively?**
Mark only one oval.

- ◯ Yes *Skip to question 90.*
- ◯ No *Skip to question 89.*

Communicating Needs

89. **Please describe how your child communicates their needs and/or requires assistance to communicate:**

Visuals

90. **Is your child familiar with the use of visuals?**
If yes, please explain how and when they are used on the next page:
Mark only one oval.

- ◯ Yes *Skip to question 91.*
- ◯ No *Skip to question 92.*

Visuals (continued)

91. **Please explain how and when visuals are used:**

Sensory

Is your child sensitive to any of the below? Please provide examples and strategies or tools used to address sensory preferences.

92. **Tactile:**

(e.g., how does your child respond to touch; handle objects/textures?)

93. **Auditory:**

(e.g., Does your child seek/avoid noise or particular sounds? Do they attend to a particular sound or tone more than others?)

94. **Smell:**

(e.g., Does your child like or dislike particular smells, is there anything soothing or distracting to them?)

95. **Movement:**

(e.g., Does your child seek or avoid movement? swing, spin, etc.)

96. **Visuals:**
(e.g., Does your child enjoy certain lights or colours? Are they sensitive to sunlight or fluorescent lighting?)

97. **Is your child aware of his/her sensitivities? How does he/she self regulate?**

Behaviour

98. **Does your child have any complex and/or challenging behaviours?**
(e.g., flight risk, aggressive, non-compliant, self-injurious, self-stimulatory). Please explain and describe:

99. **How often do the behaviours occur? What is their duration?**

100. **What are the triggers/antecedents to the complex and/or challenging behaviours?**

101. **What are the usual interventions that you find effective?**
(e.g., removed from situation, 'time out', gets what is desired)

102. **What are the most useful strategies in calming/de-escalating your child if they do become upset?**
(e.g., deep pressure, music, breathing techniques, remove from environment). Please explain:

103. **List any motivators or special interests your child may have:**

104. **How does your child do with transitioning between activities?**

105. **How does your child do with changes to routine?**

106. **Is your child able to swim?**
Mark only one oval.

- Yes
- No

107. **Please explain the amount of support he/she requires to swim:**

108. **Is your child a flight risk?**
(e.g., running away, bolting, etc.)
Mark only one oval.

- Yes *Skip to question 109.*
- No *Skip to question 110.*

Flight Risk

109. **Please explain when your child is a flight risk and what may trigger this behaviour:**

Required 1:1 supervision

110. **Does your child require 1:1 supervision?**
Mark only one oval.

- Yes
- No

111. **Please explain how your child needs 1:1 supervision:**

Additional Information

112. **Is there any other information you would like to share about your child to ensure a successful experience?**

Thank you for taking the time to fill out this form!

If you have any questions please contact Marissa at cbregion@autismns.ca or phone 902.567-2830.