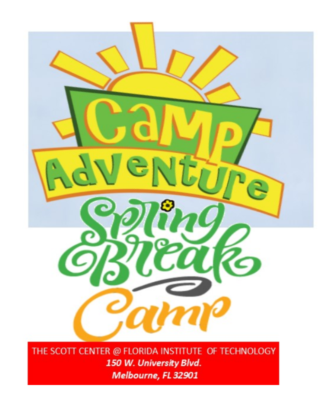
FULL NAME OF CAMPER:___________________________________

Brevard Autism Adventure Camp 2017

	***The Scott Center for Autism Treatment at Florida Institute of Technology*** ***150 W. University Blvd. Melbourne, FL 32901***	
	Camp dates ***April 10 – 14, 2017*** ***Monday-Friday 8:30-2:30***	

About Brevard Autism Adventure Camp

Brevard Autism Adventure Camp is a spring break camp designed to provide adolescents with autism ranging in age from 13-17 an opportunity for fun, socialization, exercise and creativity. ***Brevard Autism Adventure Camp*** will be held April 10 – 14, 2017 during the designated Spring Break for Brevard County Schools.

This program was developed in response to limited options and high demand for appropriate spring break programs where adolescents with ASD can have fun and make friends. *Campers with ASD must be registered with the UCF Center for Autism and Related Disabilities (CARD) to participate.*

Brevard Autism Adventure Camp is held at the Scott Center for Autism Treatment on the beautiful campus of The Florida Institute of Technology (FIT). The FIT Campus has excellent resources available for our campers including: swimming, sports, games and nature walks. The campers will be supervised by adults who are experienced in working with adolescents with ASD. The maximum number for this camp is 12 participants for the week. If the camp is full when you apply, you will be added to our waiting list.

Office Use Only
Received: ________________
Sent for Approval: __________
Approved: ________________
Input: ___________________
Charged Deposit: ___________
Charged Balance: ___________

FULL NAME OF CAMPER:_________________________________

Brevard Autism Adventure Camp 2017

Enrollment Application

Name of Child: ___________________________ **Birth Date:** _________ ____**Male** ____**Female**

** A separate Enrollment Application must be completed for each child.*

CARD Coordinator's Name: ____

School Name: ___________________________________ **Grade:** ______ **Teacher:** _______________

Teacher Phone: _______________________ **Teacher Email:** _________

Name of Sibling Attending: ____

Parent/Guardian Information

Name		Name	
Home Phone		Home Phone	
Work Phone		Work Phone	
Email		Email	
Cell/Pager		Cell/Pager	
Address		Address	
City, State Zip		City, State Zip	

Emergency Information/Permission to Pick up Child

1. Name: ____________________ Mother/Guardian Contact # ________________ Pick up: Y/N
2. Name: ____________________ Father/Guardian Contact # ________________ Pick up: Y/N
3. Name: ____________________ Relationship: ___ Contact # ________________ Pick up: Y/N
4. Name: ___________________ Relationship: ___ Contact # ________________ Pick up: Y/N
5. Name: ___________________ Relationship: ___ Contact # ________________ Pick up: Y/N

REGISTRATION/PAYMENT

☐ The above named individual will be attending Brevard Adventure Camp April 10 – 14, 2017 at a cost of $250*.

CAMPER T-SHIRT SIZE

KIDS - ☐small ☐medium ☐large
ADULTS – ☐small ☐medium ☐large ☐x-large

FULL NAME OF CAMPER:___________________________________

The following sections must be read and initialed. By initialing each section, you indicate you have read and understand the camp procedures and agree to follow the procedures established for the safety and success of all campers.
Initials:

___ **LOCATION / HOURS**
The Scott Center for Autism @ FIT – 150 W. University Blvd, Melbourne, FL 32901-6975
Camp hours are: Monday – Friday from 8:30am – 2:30pm. **** NO early drop-off or late pick-up. ****

___ **TRANSPORTATION**
Transportation **will not** be provided for daily pick-up and drop-off. Transportation will be provided for outings and/or field trips during camp hours through a contracted transportation company. The cost for transportation is included in the weekly camp fee.

___ **ACTIVITIES**
Activities for all campers will consist of:

- Arts & Crafts
- Music & Movement
- General Play Activities
- Social Skills Instruction and Development
- Outdoor games/activities
- Field Trip opportunities

___ **WHAT DO THE CAMPERS NEED TO BRING DAILY?**

- Closed-toed shoes
- Sunscreen and insect repellent
- Towel and bathing suit (on water days)
- Change of clothes
- Lunch, snacks, and water/drinks (every day unless otherwise specified)
- Lunches should be in either a Ziploc bag or brown paper bag on field trip days (coolers cannot accommodate all of the lunchboxes)
- If your child **cannot** swim, please send a **Coast Guard approved** life jacket.
- **Please label everything that is brought to Camp with your child's name.** We cannot be responsible for items that are not labeled or are lost. Some children may need to bring an extra change of clothes each day.

___ **DO NOT BRING/WEAR!**
Campers **must not bring/wear** the following items to camp:

- breakfast
- glass containers
- flip-flops, sandals, or barefoot
- pets
- personal toys
- cell phones, iPods, or electronic games
- Weapons of **any kind**.

___ **FOOD AND BEVERAGE**

- Each child needs a lunch, snack, and adequate beverages packed every day unless otherwise specified.
- All food must be non-refrigerated food (Food will be stored indoors, but you may want to supplement this with a cooler or ice pack).
- Please do not send in microwaveable food items.
- Please pack necessary utensils, napkins, plates, etc.

- Parents will be notified of any field trips where lunch or snack can be purchased or is provided.

___ **LOST AND FOUND**

A Lost and Found area will be provided for items left at camp at the end of each day. All unclaimed items will be donated to charitable organizations if not claimed one week after camp ends.

___ **MEDICATION DISTRIBUTION**

Any camper requiring medication to be administered at camp must complete a Medication Release Form. Medication **will not** be administered to a camper without this signed form. Medication must arrive in its original container with a valid expiration date, dosage directions, and prescribing physician's name. **PLEASE NOTE**: Any current medications your child is taking MUST be listed on this form under, "Medications Dosages" section even it NOT administered during camp hours.

___ **MEDICAL POLICY:**

While we realize families may choose to pursue a variety of medical and/or biological treatments, as well as medication interventions to address the specific needs of their children. It is our belief that camp is not a good time to try new treatments and/or medications or alternative treatments that may affect a child's behavior. Based upon our previous experience, ***Brevard Autism Adventure Camp*** cannot support campers who are in active biomedical treatments and/or undergoing medical trials; such as chelation, IVIG, NAET, etc. We appreciate your cooperation with this policy and your understanding.

___ **DEPOSIT**

Deposits can be paid by credit card or by check or money order made payable to Brevard PALS. A $50.00 per camper deposit is due with the Enrollment Application. Deposits are deducted from the total camp costs. Mail deposits and Enrollment Applications to: Brevard PALS c/o Child & Family Consultants-1800 Penn Street -Melbourne, FL 32901

___ **PAYMENT**

The full payment for Camp is due on or before Friday, March 31, 2017. Payments may be made by credit card or by check or money order made payable to Brevard PALS. Payments by credit card and completed and notarized applications must be mailed to 1800 Penn Street, Melbourne, FL 32901.

___ **CANCELLATIONS/REFUNDS**

If your application is received after the maximum number of available camp slots are filled – you will be placed on a waiting list for camp. If the number of applicants exceeds 12 per week, your child will be placed on a waiting list and you will be notified by April 3, 2017 to participate in ***Brevard Autism Adventure Camp.*** No refunds will be made after **April 3, 2017**. **No exceptions**. This includes non-attendance due to illness of camper or personal family situations. **A one-time $30.00 Processing Fee will be deducted from any cancellation accepted by Brevard Autism Adventure Camp**. *(Please note that it may take 4-6 weeks for a refund check to be processed)*

___ **DISMISSAL FROM CAMP**

Dismissal from camp may occur for any camp participant after conducting a functional assessment and providing appropriate behavior strategies, determines that the adult-child ratio cannot support the safety of the camper or the group. **Please note the staffing ratio is not designed for campers who need full-time, one-on-one assistance or who have significant behaviors such as self-injury, aggression, elopement, safety, etc.**

FULL NAME OF CAMPER:________________________________

All About Me

Please use this page to tell the camp staff about your child

Things I like - List things that your child really likes. Example: play dough, books, animals, etc.

1. ________________________ 4. ________________________
2. ________________________ 5. ________________________
3. ________________________ 6. ________________________

Things I don't like - List things that your child doesn't like or avoids. Example: loud noises, water, sand, etc.

1. ________________________ 4. ________________________
2. ________________________ 5. ________________________
3. ________________________ 6. ________________________

Communication- **Please send any communication system used with child.**

___Nonverbal ___Some Language ___Fully Verbal ___ Device
___Sign Language ___Picture Symbols ___Communication Board

Please indicate how your child communicates his/her needs. For example: points to things, becomes very loud when upset, says "red" for "juice," etc.

____

____

In order for Brevard Autism Adventure Camp staff to safely support and manage your child at camp and in the community, we need to know about any behaviors that may adversely affect his/her ability, and others', to participate in all activities.
PLEASE NOTE: Campers must be able to be managed in a **1:4 staff to camper ratio** and manageable in a group setting of 10-20 campers (i.e. field trips).

Behaviors: List any behaviors that may affect your child's ability to safely participate in activities or with others. **Include a copy of your child's individual behavior plan (if applicable) with the completed application form**.

1. ____
2. ____
3. ____

FULL NAME OF CAMPER:________________________________

Medical Background:

***All areas on this form must be completed. An incomplete medical form will result in an incomplete camp application.**

Physician's Name:_________________________ Phone:__________________________________

Last Tetanus shot date: __/___/____

Medical Insurance Company for Child: ____

Insurance Company Phone: _____________________ Policy Number: _______________________

Does your child have a disability? __Yes __No If yes, what: _______________________________

Does your child have any chronic illnesses? __Yes __No If yes, what: __________________________

Does child have physical restrictions/limitations? __Yes __No If yes, what: ___________________

Is your child subject to seizures? __Yes __No Type: _____________ Frequency: ____________

Is your child subject to blood sugar level issues? Yes __No If yes, low or high: ____________________

Other special Conditions: ____

Is child on special diet? __Yes __No If yes, please explain:

____

Does your child require assistance while eating? __Yes __No If yes, please explain:

____

Your child must be toilet trained ___ initials

Allergies to drugs, foods, insects? __Yes __No If yes, what:

____

Is child taking medication? __Yes __No NOTE: If yes, please complete and sign the Medication Release in this packet. All current medications must be listed here, even if they are not going to be administered during camp hours. In case of emergency it is critical that camp staff know about any medication a camper may be taking.

Please list all medications and dosages: (ALL current medications must be listed on this form)

1.______________________________________ 2. ______________________________________

3.______________________________________ 4. ______________________________________

5. _____________________________________ 6.______________________________________

If additional information is needed please use an additional paper. All of this information is required and very important. Your child's safety & welfare is our number 1 concern at all times.

FULL NAME OF CAMPER:________________________________

MEDICATION RELEASE

I give permission for my child, ________________________________ , to have his/her oral medication administered to him/her during camp hours by a Brevard Autism Adventure Camp staff person.

My child will need the following medication(s) and dosage(s) administered during camp hours:

MEDICATION	DOSAGE	TIME

Special instructions for administering medication:

____

____

Parent/Guardian____ Date__________________

Medication must be provided in its original container from pharmacy with dosage amount, directions, and prescribing physician name. If not, medication will not be administered.

FULL NAME OF CAMPER:_______________________________

WAIVERS/RELEASE FORMS

Release Forms for participation are required by the state of Florida for any individual participating in any activity under Status 744.301 and by each entity. There are two required for Brevard Adventure Camp. One for FIT and one for Brevard PALS.

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF PROVIDING AUTISM LINKS AND SUPPORTS (PALS) USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM PALS IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND PALS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I, the undersigned, assume all risks and hazards of the conduct of the program. In case of the unlikely event my child should be injured during this PALS subsidized program, I do hereby waive all claims or legal actions, financial, or otherwise against UCF Center for Autism and Related Disabilities (CARD), Providing Autism Links & Support (PALS),The Scott Center, Florida Institute of Technology, Brevard PALS, their elected officials, and employees, supervisors, or any volunteers or contracted individuals/corporation/entities connected with the program and hold them harmless of indemnification. In absence of a signature, participation in the program shall constitute acceptance of the conditions set forth in the release. I have provided the program with information regarding all medications and all dosages required during program hours. I also agree to emergency treatment by a physician or hospital in the event that I cannot be reached.

The Program, PALS and CARD are not responsible for items brought from home. For the safety of your child, please have your child prepared for activities (e.g. no sandals, flip-flops, or open toed shoes). Please make sure that your child wears clothing that is secure since many activities require a high level of energy (e.g. running, hopping, etc.) and for protection.

I understand that my child (or self) may be dismissed from participation and I agree to remove my child (or self) within one hour of being notified of any violation of the Program Code of Conduct.

FULL NAME OF CAMPER:____________________________________

I understand registrations may be submitted by mail or in person, and registrations by telephone will not be accepted. I understand that to register I must complete the Enrollment Application and send in payment for my child or children

WAIVERS/RELEASE FORMS

(page 2of 2)

in full by April 3, 2017. (Incomplete applications and/or applications without proper camp fees will not be accepted.) I understand payments will be processed as they are received on a first come first serve basis, but this does not
guarantee placement for my child. ***I understand that if my balance owed is not received by April 3, 2017, my child will lose his/her slot in the camp program.*** *I understand there is a cancellation policy and no refunds will be made after April 3, 2017.* ***I understand that if my child cannot be served at the camp due to behaviors that may present a danger to self or others or that cannot be managed by staff, a refund check for any remaining time will be issued.*** *I am aware this camp program is not a Brevard County Public School program.*

I hereby give my consent for ____ to participate in Brevard Autism Adventure Camp.

Child's name

Participant's Parent/Guardian____ Date_________________

PHOTO RELEASE

I hereby grant permission for the above stated Camp participant to appear in still or motion pictures for educational, promotional, or other proper purposes only. ___Yes ___No

Participant's Parent/Guardian____ Date_________________

TRAVEL RELEASE

I hereby grant permission for the above stated Camp participant to travel on a School Wheels Direct bus for field trips to various locations. I understand that Camp personnel will provide supervision during transportation and field trips, and that one on one staffing is not possible. I understand that field trips depart on time per the schedule, and no one will accept my child at the camp location after the bus has left. I also understand no refunds will be provided for days on which my child has missed the bus for pool or field trips.

Participant's Parent/Guardian____ Date_________________

SWIM RELEASE

I hereby grant permission for the above stated Camp participant to swim in the FIT pool. I understand that campers will be tested for swimming ability on their first day of camp. Those campers that the counselors/pool staff feel are not competent swimmers will need to bring Coast Guard approved flotation devices which should be supplied by parents. I understand that no campers may stay behind at camp during field trips.

Participant's Parent/Guardian____ Date_________________

All camper registrations must be notarized.

State of Florida County of ______________________________

The foregoing instrument was acknowledged before me this _________ day of ______________________, 201__ by ____ who is personally known to me and/or produced ____ as identification and did/(not) take an oath.

____

FULL NAME OF CAMPER:____________________________________

Notary

FULL NAME OF CAMPER:_______________________________

CREDIT CARD AUTHORIZATION FORM

Credit Card Number _______________________________

Expiration Date _____ / _____ VID Code: ________ (VID code is three digit code on back of card) **4 digits on front for Amex*

Cardholder (as appears on credit card): _______________________________

CREDIT CARD BILLING ADDRESS

Name: _______________________________

Organization: _______________________________

Street: _______________________________

City: ____________________ State: ________ Zip Code: __________

Telephone: ____________________ Email: ____________________

PLEASE CHOOSE PREFERRED CHARGE METHOD

I, Cardholder listed above, hereby authorize Providing Autism Links & Support, Inc. (PALS, Inc.) to charge my credit card account

☐ I authorize PALS to charge the full amount of $250. plus the $10 processing fee for a total of $260 upon receipt of this application.

☐ A deposit of $50, plus a $5 processing fee, for a total of $55 and I understand by checking this box ☐ I authorize PALS to charge the balance of $200, plus the $10 processing fee for a total of $210 on **April 3, 2017.**

☐ Only charge my deposit I will forward a check to the address below for the balance before March 04, 2016.

**Camp is offered at a very low cost while providing a high level of expert staff. Thanks to the support of CARD and PALS this is possible. Processing fees enable us to apply full payment to the camp program.*

_______________________________ Cardholder Signature

_______________ Date (MM/DD/YYYY)

Your completion of this authorization form helps us to protect you from credit card fraud.

All information entered on this form will be kept strictly confidential.

Brevard PALS, Inc. Tax ID: 01-0717788

Brevard PALS c/o Child & Family Consultant's

1800 Penn Street, Melbourne, FL 32901-6975

Questions: 321-768-6800