



# 2012 SIBLING APPLICATION

Camp Holiday Trails' mission is to **empower, encourage, and educate** children with chronic illnesses, their families, and healthcare professionals by providing a summer camp and year-round programming aimed at personal growth.

**Session 1 & Session 4  
ONLY**

Making Summer Memories for Kids With Special Medical Needs



...In the Heart of the Blue Ridge Mountains since 1973

Camp Holiday Trails...A co-ed, residential Camp for children with special medical needs, serving children ages 7 – 17 (age 5 for Session 1!), with varied diagnoses.

All campers must function at a cognitive/behavioral level within 1 or 2 years of their actual age.

## **To Complete CHT's Sibling Application:**

- STEP 1** Please contact your child's school to obtain his/her immunization record. This is a critical piece of your child's application – we **MUST** have it **BEFORE** our doctors begin their review.
- STEP 2** Please make an appointment with your child's physician **NOW!** Your child must be seen by his/her physician on or after 8/15/2011 Hint: it may be possible to save on cost or insurance to make this part of a regular checkup appointment vs. a special camp physical appointment) Your child's physician must complete pp 9 and return the form directly to CHT.
- STEP 3** Please talk with your child's **Teacher, Guidance Counselor, Social Worker, or Therapist** and ask them to complete the Behavioral Assessment. S/he should complete pp 11-12 and return them directly to CHT.
- STEP 4** Please complete pp 1-8 of the Sibling Application and return to CHT. Send in these pages as soon as possible to open your child's chart and hold the spot. We will add the Medical Assessment and the Behavioral Assessment to the chart as we receive them.
- STEP 5** Due to increased enrollment, we have instituted **rolling deadlines**. These deadlines are **FIRM** and must be met for your child to attend Camp. Please make yourself aware of the deadline pertinent to your child – noted in the Camp Dates section of the application on page 2.

400 Holiday Trails Lane · Charlottesville, VA 22903

Phone: (434)977-3781 · Fax: (434)977-8814

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Sibling Name \_\_\_\_\_

2012 CAMP DATES – TO BE COMPLETED BY PARENT/GUARDIAN

Please choose **ONE**:

**SESSION 1 – YOUNG CAMPER WEEK:** *June 17 - 22*

One-week session open to campers (ages 5 – 12) and their siblings (ages 5 – 12); Family Partnership portion of Camper fee: \$120 (Actual Camper fee: \$1250). Amount paid above Family Partnership Fee is a donation to our Campership Fund and allows more kids to have the CHT Camp experience!

**DEADLINE FOR APPLICATION: May 18, 2012**

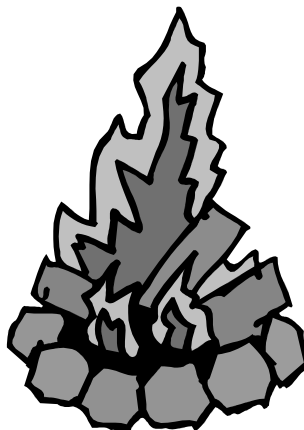
**SESSION 4 – CAMP YOUNGBLOOD with Virginia Hemophilia Foundation:** *July 22 - 27*

For children with a bleeding disorder (ages 7 – 17) and their siblings (ages 7 – 17); Fee: \$25, *refunded once camper attends* - VA Hemophilia Foundation fundraises to pay for the camp experience. We do **require** that all Camp Youngblood families fill out the attached “Campership + Summer Meals” Form (it helps defray the cost of food!) **DEADLINE FOR APPLICATION: June 22, 2012**

**This child is the sibling of:** \_\_\_\_\_  
(camper with special medical need)

**How did you hear about Camp Holiday Trails?** \_\_\_\_\_

**Has your child ever attended Camp Holiday Trails before?**  Yes - What year(s)? \_\_\_\_\_  No - we're new!



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Sibling Name \_\_\_\_\_



## GENERAL INFORMATION

If you have any questions or need any assistance while completing this application, our staff is here to help! Just call (434-977-3781) or e-mail [campisgood@campholidaytrails.org](mailto:campisgood@campholidaytrails.org)

### A. SIBLING INFORMATION – TO BE COMPLETED BY PARENT/GUARDIAN

Sibling Name: \_\_\_\_\_  Male  Female

DOB: \_\_\_\_\_ Age (at time of camp): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### B. CONTACT INFORMATION – TO BE COMPLETED BY PARENT/GUARDIAN

MOTHER/GUARDIAN Name: \_\_\_\_\_

Home Ph. # (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_  
*(at least one email is required)*

Cell Ph. # (\_\_\_\_) \_\_\_\_\_

Work Ph. # (\_\_\_\_) \_\_\_\_\_

FATHER/GUARDIAN Name: \_\_\_\_\_

Home Ph. # (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_  
*(at least one email is required)*

Cell Ph. # (\_\_\_\_) \_\_\_\_\_

Work Ph. # (\_\_\_\_) \_\_\_\_\_

We need to be able to reach families by **both** phone & email.

Who has legal custody of this child? \_\_\_\_\_ Relationship? \_\_\_\_\_

**Emergency Contact Information:** Someone **other than a parent or guardian** must be available **at all times** in case of emergency. This person will only be contacted if we have difficulty reaching you.

EMERGENCY CONTACT Name: \_\_\_\_\_

Home Ph. # (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Cell Ph. # (\_\_\_\_) \_\_\_\_\_

Work Ph. # (\_\_\_\_) \_\_\_\_\_

### C. MEDICAL CONTACT – TO BE COMPLETED BY PARENT/GUARDIAN

PRIMARY CARE PHYSICIAN Name: \_\_\_\_\_

Office Ph. # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Ph. # (\_\_\_\_) \_\_\_\_\_

Fax Ph. # (\_\_\_\_) \_\_\_\_\_

SPECIALIST Name: \_\_\_\_\_

Office Ph. # (\_\_\_\_) \_\_\_\_\_

Hospital Affiliation (if applicable): \_\_\_\_\_

Emergency Ph. # (\_\_\_\_) \_\_\_\_\_

Fax Ph. # (\_\_\_\_) \_\_\_\_\_

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# Sibling Name \_\_\_\_\_

## D. GENERAL MEDICAL INFORMATION – TO BE COMPLETED BY PARENT/GUARDIAN

**MEDICAL CHALLENGES:** Please describe any medical challenges your child has: \_\_\_\_\_

**COGNITIVE or BEHAVIORAL CONDITIONS:** Please describe any cognitive/behavioral conditions your child has:

*(Siblings must function at a cognitive/behavioral level within 1 or 2 years of their actual age)*

**ALLERGIES:** Does your child have any FOOD, DRUG, INSECT, LATEX, or OTHER allergies?  Yes  No  
If yes, please specify using the GRID below to identify & describe.

ALLERGY	REACTION (*Please note if ANAPHYLACTIC*)	TREATMENT

**DIETARY NEEDS:** Does your child have any special dietary needs?  Yes  No

If yes, please describe: \_\_\_\_\_

**MOBILITY CHALLENGES:** Does your child use/have any of the following? Please check all that apply:

None  Wheelchair (circle one: power/manual)  Walker  Crutches  Splint  AFOs  Prosthetic  Other

Please detail any problems with muscle tone, range of motion or strength OR any other physical limitations:

**MEDICATIONS & TREATMENTS:** Routine and PRN (*attach additional sheet if necessary*)

Check here if you have included a separate medication list in lieu of filling out the section below

MEDICATION/TREATMENT	DOSE	ROUTE	FREQUENCY

## Sibling Name \_\_\_\_\_

Is there any other information you would like us to know about your child's medical challenge (*if applicable*) that would help us provide a more rewarding camp experience? \_\_\_\_\_

### E. REQUIRED IMMUNIZATION RECORDS – TO BE OBTAINED BY PARENT/GUARDIAN

Camp Holiday Trails follows the American Academy of Pediatrics guidelines for camps.

**IMPORTANT – YOU MUST ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD  
PROOF OF IMMUNIZATIONS LISTED BELOW IS REQUIRED FOR YOUR CHILD TO BE ACCEPTED TO CAMP.**

**Note: It is best for you to obtain this record from your child's school.**

- **DTap** (diphtheria, tetanus & pertussis)
- **Tdap** (If 11 years or older)
- **HIB** (Haemophilus influenza vaccine)
- **IPV** (polio vaccine)
- **PCV** (pneumococcal vaccine)
- **MMR** (measles, mumps & rubella)
- **Hepatitis B** vaccine
- **Meningococcal** (If 11 years or older)
- **Varicella vaccine** (chicken pox), UNLESS child has had chicken pox. Date: \_\_\_\_\_
- If tested, **HIV** status: \_\_\_\_\_ (Children who are HIV+ are not required to receive MMR and Varicella vaccines.)

If for any reason your child has not received all of the required vaccinations listed to the left, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### F. SIBLING BEHAVIORAL ASSESSMENT – TO BE COMPLETED BY PARENT/GUARDIAN

It is important to us that we get to know each child **before** they come to camp. Please complete these questions which will assist us in determining how to maximize your child's camp experience.

Does your child **require physical assistance** (including help with showering, toileting, dressing and hygiene) at home/in school?  Yes  No

If yes, please identify level of assistance:  Minimal  Moderate  Maximal/1:1 Assistance

Please give examples: \_\_\_\_\_

How does your child **make his/her needs known**? How do you communicate with him/her? \_\_\_\_\_  
\_\_\_\_\_

Camp Holiday Trails plans activities for children ages 7 – 17 (5 – 12 for Session 1).

**Siblings must function at a cognitive/behavioral level within 1 or 2 years of their actual age.** At what age does your child function? Please consider how your child functions socially (at school and in interactions with his/her peers). This information will help us to place your child in the best cabin group for him/her.

- Younger than 7  Age 7 – 8  Age 9 – 10  Age 11 – 12  Age 13 – 14  Age 15 – 17

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# Sibling Name \_\_\_\_\_

Please answer the following questions about your child's interests, home life, and behavior.

What are your **child's favorite activities** (books, music, etc.)? \_\_\_\_\_

Have there been **any significant changes in your child's home life** over the past year (i.e. – moving, separation, divorce, adoption, death in the family, loss of employment, etc.)?  Yes  No

If yes, please explain: \_\_\_\_\_

How does your child behave in **non-classroom settings** (i.e. – PE, recess, art, with friends)? \_\_\_\_\_

Has your child ever been suspended from school or faced **disciplinary action**?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child ever **harmed him/herself**?  Yes  No If yes, please explain: \_\_\_\_\_

Has your child ever **harmed others**?  Yes  No If yes, please explain: \_\_\_\_\_

Has your child ever talked about or actually **run away**?  Yes  No If yes, please explain: \_\_\_\_\_

Is there **any other information we should know** that will help us provide a more rewarding experience for your child? Any challenges you would like our Staff to help your child manage? \_\_\_\_\_

## G. PARENT/GUARDIAN SIGNATURE – TO BE COMPLETED BY PARENT/GUARDIAN

**I have completed pages 1-6 of this application to the best of my knowledge. I understand that incomplete or inaccurate information may result in the inability of this camper to participate in the Camp Holiday Trails program.**

Name of person who completed this application: \_\_\_\_\_

*(if different from Parent/Guardian)*

Relationship to applicant: \_\_\_\_\_ Contact info: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Please send pages 1-8 directly to Camp Holiday Trails as soon as you complete them so we can open your child's chart. We will add the Camper Medical Assessment and Camper Behavioral Assessment to the chart when they arrive at CHT.  
**THANK YOU!**

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# Sibling Name \_\_\_\_\_

## H. CAMPERSHIP & SUMMER MEALS APPLICATION – TO BE COMPLETED BY PARENT/GUARDIAN

**Directions: Completion of this form is required for EVERY SESSION in order to submit the Sibling Application for review.**

**Camp fees: We understand the challenges our camp families face each and every day. The actual cost of attending Camp Holiday Trails is \$1,250 for a 1-week session and \$2,500 for 2-weeks; we are committed to offering CHT to all campers with a special health need, regardless of ability or inability to pay, so we fundraise to allow families to pay a minimum of \$120. We DO ask our families to partner with us and **TOGETHER** we will send your child to Camp!**

The minimum Family Partnership portion of the payment is \$120.

This is possible thanks to our generous donors and fundraising efforts.

**If you need assistance:** Call Camp for a sample letter to give to an employer, school, church, neighbors, family, friends, or anyone who can help you get to Camp!

**We are committed to making our camp available to as many children as possible, regardless of ability to pay...if you have the ability to pay more, please know that every dollar that a family can pay, above \$120, helps contribute to the Campership Fund, allowing more campers in need to attend Camp. **We are counting on you to help spread our dollars and help more kids attend Camp!****

1. Camper Name \_\_\_\_\_  
Last Name First Name

New Camper  Returning Camper

2. Foster Child? YES  NO  If yes, child's monthly personal income: \$ \_\_\_\_\_ (Go to #5)

3. Food Stamps, TANF or FDPIR benefits. Please list CASE #.

Food Stamp case #: \_\_\_\_\_ TANF case #: \_\_\_\_\_ FDPIR case #: \_\_\_\_\_ (Go to #5)

4.

Names of Household Members (include child above)	Monthly Earnings from Work, Job 1 (before deductions)	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Monthly Earnings from Job 2 or Any Other Monthly Income
1.				
2.				
3.				
4.				
5.				
6.				

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# Sibling Name \_\_\_\_\_

5. I certify that all of the above information is true and correct and that the food stamp, TANF, FDPIR or other eligible program case number is current, correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds (Summer Meals for Kids) and that institution officials may verify the information and that the deliberate misrepresentation of information may subject me to prosecution under applicable State and Federal law.

Signature of Adult: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Print Name: \_\_\_\_\_ Home Ph.: \_\_\_\_\_ Work Ph.: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Our fees are used to maintain a safe camp, to keep our counselor : camper ratios low, to provide housing for MDs to live at Camp, to stock and staff Med Korner, to feed every Camper 3 meals and 3 snacks a day ... Please remember, we are a CHT family. Give when you can to help others. You know their challenges.**

**I will be paying the Family Partnership portion of Camper fee: \$120**  
*(for 1 OR 2 week camps as 1 week camps are smaller with different staff ratios)*

**I can pay this additional amount towards the Camper fee so that the financial aid available can be used to send more kids to Camp:**

\$ \_\_\_\_\_

**Amount CHT will contribute:**

\$ \_\_\_\_\_ (office use only)

**TOTAL ACTUAL CAMP FEE**

**\$2500 (2 weeks) OR \$1250 (1 week)**

The US Dept. of Agriculture (USDA) prohibits discrimination in all of its program and activities on the basis of race, color, national origin, gender, age or disability. Person with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD.)

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Rm. 326-W, Whitten Bldg., 14<sup>th</sup> & Independence SW, Wash., DC 20250-9410 or call (202) 720-5964 (voice and TDD.) USDA is an equal opportunity provider and employer.

**Privacy Act Statement:** Unless you list the child's food stamp, FDPIR or TANF case # or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security # of the household member signing the form or indicate that the household member signing the form does not have a social security #. You do not have to list the social security #, but if the social security # is not listed, or an indication is not made that the adult household member signing the form does not have a social security #, we cannot approve the form. The social security # may be used to identify the household member in verifying correctness of information stated on the form. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received, and checking documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The social security # may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the US, and law enforcement officials of investigating violations of certain Federal, State and local education, health and nutrition programs.

## FOR OFFICE USE ONLY:

Food Stamp/TANF/FDPIR or other eligible program benefit eligibility: YES  NO  If NO, Monthly Income Conversion: \_\_\_\_\_

Total monthly income: \$ \_\_\_\_\_ Household size: \_\_\_\_\_ Eligible: YES  NO

Determining official: \_\_\_\_\_ (print) \_\_\_\_\_ (signature) Date: \_\_\_\_\_

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Sibling Name \_\_\_\_\_



# MEDICAL ASSESSMENT

Thank you for helping this child go to Camp! Please complete this page, then fax the form directly to Camp Holiday Trails at 434-977-8814.

## A. HEALTH EXAM – TO BE COMPLETED BY PHYSICIAN

Date of exam: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lb  
(must be on or after 8/15/11)

Pertinent Physical Exam Findings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain any medical challenges this child has: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this child developmentally appropriate for his/her age?  Yes  No - at what age does the child function?: \_\_\_\_\_

Has this child had his/her appendix removed?  Yes  No

Please list any other previous surgeries: \_\_\_\_\_  
\_\_\_\_\_

Please list any hospitalizations (within the last 12 months): \_\_\_\_\_  
\_\_\_\_\_

Is there any other information we should know that will help us meet the medical needs of and provide a safe Camp experience for this child?  
\_\_\_\_\_  
\_\_\_\_\_

## B. PHYSICIAN/MEDICAL PROFESSIONAL RECOMMENDATION – TO BE COMPLETED BY PHYSICIAN

I have seen and examined this patient on or after 8/15/2011, and I believe based on my knowledge that this patient SHOULD/SHOULD NOT - circle one - be considered for acceptance at Camp Holiday Trails. I have examined this child and find him/her physically able to attend camp.

If you are NOT recommending this child, please explain: \_\_\_\_\_

Provider's Signature

Print Name

Date

Clinic Name

Hospital Affiliation

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone Emergency/On Call Phone Fax

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**Sibling Name** \_\_\_\_\_

**THIS PAGE LEFT BLANK**

Sibling Name \_\_\_\_\_



# BEHAVIORAL ASSESSMENT

Thank you for helping this child go to Camp! Please complete pages 11-12, then fax the forms directly to Camp Holiday Trails at 434-977-8814.

**To be completed by a Child Development Professional (teacher, guidance counselor, social worker, therapist)**  
**All Information in this form will be treated as personal and confidential**

The person who asked you to complete this form is applying for their child to attend Camp Holiday Trails (CHT). CHT is a special place that gives children with chronic illnesses and special medical needs the chance to experience a traditional camp. Our Med Staff work 24 hours a day in an on-site clinic and we have one adult counselor for every three campers. In all other respects, CHT is a traditional summer camp, with all the outdoor summer activities children love – and opportunities to develop self-confidence, build self-esteem, foster independence and better manage their healthcare. During some sessions we have the opportunity to welcome siblings of a child with special health needs to our Camp. The child concerned in this assessment is applying to attend CHT for a one-week residential camp experience *with their sibling who has a special medical need.*

**All of our campers, including siblings, should function cognitive/behaviorally within 1 or 2 years of their actual age** and be, for the most part, independent.

Your cooperation and accuracy with the completion of this form will ensure a positive camp experience for all of our campers and will help us make an appropriate individualized assessment of the applicant's abilities.

## A. GENERAL INFORMATION – TO BE COMPLETED BY A CHILD DEVELOPMENT PROFESSIONAL

Child's Name: \_\_\_\_\_ Child's Grade: \_\_\_\_\_  
Your Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Daytime Phone #: (\_\_\_\_\_) \_\_\_\_\_ Evening Phone #: (\_\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_

## B. COGNITIVE/BEHAVIORAL INFORMATION – TO BE COMPLETED BY A CHILD DEVELOPMENT PROFESSIONAL

How long have you known this child? \_\_\_\_\_ In what capacity do you know this child? \_\_\_\_\_  
How often do you see this child? \_\_\_\_\_  
Describe your interactions with this child: \_\_\_\_\_  
\_\_\_\_\_

How does this child respond to **limits or directions** from you? \_\_\_\_\_  
\_\_\_\_\_

From others? \_\_\_\_\_  
\_\_\_\_\_

Does this child exhibit any **fears or phobias**? \_\_\_\_\_  
\_\_\_\_\_

Do you have any **behavior concerns** about this child?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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# Sibling Name \_\_\_\_\_

How does this child **interact with his/her peers**? \_\_\_\_\_

Have you observed **emotional outbursts** from this child?  Yes  No If yes, please explain: \_\_\_\_\_

How does this child behave in **non-classroom settings** (i.e. – PE, recess, art)? \_\_\_\_\_

Has this child ever been suspended from school or faced **disciplinary action**?  Yes  No

If yes, please explain: \_\_\_\_\_

Has this child ever **harmed him/herself**?  Yes  No If yes, please explain: \_\_\_\_\_

Has this child ever **harmed others**?  Yes  No If yes, please explain: \_\_\_\_\_

Has this child ever talked about or actually **run away**?  Yes  No If yes, please explain: \_\_\_\_\_

Overall do you consider the applicant to be: (check ALL that apply)

- Emotionally immature  Mature  Shy  Outgoing  Age Appropriate

At what (approximate) age does this child function: \_\_\_\_\_

What role can we play in fostering or increasing this child's sense of independence? \_\_\_\_\_

Would you recommend this child for a **residential/overnight camp experience**?

- Yes, absolutely  Yes, with some reservation  Possibly  No

Please explain: \_\_\_\_\_

Please provide us with any additional pertinent information regarding this child: \_\_\_\_\_

## C. PROFESSIONAL RECOMMENDATION – TO BE COMPLETED BY A CHILD DEVELOPMENT PROFESSIONAL

I have completed the Behavioral Assessment, and I believe based on my knowledge that this child SHOULD/SHOULD NOT – **circle one** - be considered for acceptance at Camp Holiday Trails. If you are NOT recommending this child, please explain:

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

**Thank you again for taking the time to complete this form.  
Please fax the form directly to Camp Holiday Trails at 434-977-8814.**

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