

**LYNN SPECIAL NEEDS CAMP
250 COMMERCIAL STREET
LYNN, MA 01905
(781) 477-7096**

CHILD'S NAME: _____

SOCIAL SECURITY #: ___ / ___ / _____

DATE OF BIRTH: ___ / ___ / ___ **PLACE OF BIRTH:** _____

LANGUAGE OF HOME: _____ **AGE:** _____ **SEX:** _____

HOME ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

HOME PHONE NUMBER: () _____

FATHER'S NAME: _____

PLACE OF BIRTH: _____

HOME ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

HOME PHONE: () _____ **CELL PHONE:** () _____

PLACE OF EMPLOYMENT: _____

EMPLOYMENT ADDRESS: _____

WORK PHONE: () _____

MOTHER'S NAME: _____

PLACE OF BIRTH: _____

HOME ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

HOME PHONE: () _____ **CELL PHONE:** () _____

PLACE OF EMPLOYMENT: _____

EMPLOYMENT ADDRESS: _____

WORK PHONE: () _____

NAME OF LEGAL GUARDIAN: _____

ETHNIC GROUP (PLEASE CHECK ONE):

____ CAUCASIAN ____ BLACK
____ HISPANIC ____ ASIAN
____ NATIVE AMERICAN/ALASKAN
____ OTHER

**PLEASE CHECK OFF YOUR COMBINED FAMILY INCOME:
(WE MUST HAVE THIS INFORMATION FOR ADMINISTRATIVE PURPOSES ONLY)**

\$0-9,999	_____	\$30,000 – 39,999	_____
\$10,000 - 19,999	_____	\$40,000 – 49,999	_____
\$20,000 - 29,999	_____	\$50,000 – UP	_____

TOTAL HOUSEHOLD SIZE (HOME MANY PEOPLE LIVE IN HOUSE): _____

EMERGENCY CONTACTS MUST BE PROVIDED (OTHER THAN MOTHER/FATHER):

1. NAME: _____ **HOME PHONE:** () _____

ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

CELL PHONE: () _____ **WORK PHONE:** () _____

RELATIONSHIP TO THE CHILD: _____

2. NAME: _____ **HOME PHONE:** () _____

ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

CELL PHONE: () _____ **WORK PHONE:** () _____

RELATIONSHIP TO THE CHILD: _____

3. SOCIAL WORKER/THERAPIST NAME: _____

NAME OF AGENCY: _____

ADDRESS: _____
(STREET) (CITY) (ZIP CODE)

CELL PHONE: () _____ **WORK PHONE:** () _____

WILL YOUR CHILD NEED TRANSPORTATION? _____ YES _____ NO

TRANSPORTATION PROVIDED TO LYNN RESIDENTS ONLY

**** PLEASE NOTE****

IN ORDER FOR YOUR CHILD TO LEAVE CAMP PREMISES WITH ANY PERSON, WE NEED TO HAVE WRITTEN PERMISSION FROM THE LEAGAL GUARDIAN

1. TO ATTEND FIELD TRIPS UNDER STAFF SUPERVISION THAT WILL REQUIRE TRAVEL OFF CAMP PREMISES WITHIN MASSACHUSETTS

_____ YES _____ NO

2. TO PROVIDE REQUIRED HEALTH RECORDS

_____ YES _____ NO

3. TO WALK MY CHILD TO THE BUS/VAN PICKUP AND MEET THE BUS/VAN WHEN HE/SHE IS BROUGHT HOME.

_____ YES _____ NO

4. MY CHILD TO BE TRANSPORTED IN PROGRAM VEHICLES, INCLUDING THE CAMP VANS.

_____ YES _____ NO

5. MY CHILD TO HAVE PHOTOGRAPHS TAKEN THAT MAY BY USED TO DESCRIBE PROGRAMS, RECOGNIZE ACCOMPLISHMENTS, AND/OR PUBLIC RELATIONS.

_____ YES _____ NO

6. MY CHILD TO BE INCLUDED IN VIDEO RECORDINGS THAT MAY BY PREPARED FOR IN-SERVICE TRAINING, ORIENTATION, AND/OR PUBLIC RELATIONS.

_____ YES _____ NO

7. TO PUBLISH MY CHILD'S NAME IN A CAMP NEWSLETTER AND/OR NEWSPAPER.

_____ YES _____ NO

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____ / _____ / _____

SKILLS AND BEHAVIR CHECKLIST

WHAT RECREATIONAL ACTIVITIES DOES YOUR CHILD ENJOY?

TRACK & FIELD	_____	SEWING	_____	FIELD HOCKEY	_____
SOCCER	_____	PAINTING	_____	CRAFTS	_____
BASEBALL	_____	COLORING	_____	BASKETBALL	_____
COOKING	_____	NATURE	_____	HIKING	_____
GARDENING	_____	SKATING	_____	SWIMMING	_____
MUSIC	_____	DANCING	_____	DRAMA	_____

OTHERS: _____

ARE THERE ANY ADAPTATIONS THAT WE MIGHT MAKE TO ASSURE YOUR CHILD'S PARTICIPATION IN CAMP ACTIVITIES? _____

ARE THERE ANY ACTIVITIES IN WHICH YOU WOULD LIKE US TO ENCOURAGE YOUR CHILD'S PARTICIPATION? _____

PLEASE STATE YOUR CHILD'S SWIMMING ABILITY AND ATTITUDE TOWARDS WATER: _____

TOILIETING SKILLS:

COMPLETELY TRAINED: _____ NOT TOLIET TRAINED: _____

TRAINED BUT HAS OCCASIONAL ACCIDENTS: _____

HAS FEW ACCIDENTS IF TOILETED REGULARLY: _____

SOCIAL & BEHAVIORAL CHECKLIST:

	YES	NO
ACTIVE MEMBER IN A GROUP	_____	_____
IS A GOOD SPORT	_____	_____
CAN COMPLETE A GAME	_____	_____
TIRES QUICKLY OF ONE GAME	_____	_____
ENJOYS BEING A HELPER	_____	_____
ENJOYS GAMES WITH SET RULES	_____	_____
ABLE TO CARE FOR BELONGINGS	_____	_____
PREFERS TO PLAY WITH ADULTS	_____	_____
PREFERS TO PLAY ALONE	_____	_____
PARTICIPATES IN TEAM GAMES	_____	_____
IS SHY WITH ADULTS	_____	_____
CANNOT FOLLOW RULES	_____	_____
PLAYS COOPERATIVELY WITH OTHERS	_____	_____
WILL CONFORM TO GROUP RULES	_____	_____
REQUIRES CLOSE ADULT SUPERVISION	_____	_____
LACKS DISCIPLINE	_____	_____
HAS BEEN KEPT CLOSE TO HOME	_____	_____
WILL STRAY FROM GROUP IF NOT CLOSELY SUPERVISED	_____	_____

MEDICAL HISTORY FORM

CHILD'S NAME: _____

PLEASE PROVIDE US WITH A LIST OF ALL DOCTORS, NEIGHBORHOOD HEALTH CENTERS, CLINCS, ETC. , WHERE YOUR CHILD CURRENTLY RECIEVES CARE WITH PHONE NUMBERS TO ALL PLACES:

DOCTOR'S NAME: _____ PHONE #: () _____

ADDRESS: _____ FAX #: () _____

HEALTH CENTER: _____ PHONE #: () _____

ADDRESS: _____ FAX #: () _____

* ANY ADDITIONAL: _____ PHONE #: () _____

ADDRESS: _____ FAX #: () _____

FAMILY HISTORY:

FATHER'S D.O.B. : _____ / _____ / _____ STATE OF HEALTH: _____

MOTHER'S D.O.B. : _____ / _____ / _____ STATE OF HEALTH: _____

SIBLINGS:

NAME	D.O.B.	SEX	STATE OF HEALTH
_____	_____/_____/_____	_____	_____
_____	_____/_____/_____	_____	_____
_____	_____/_____/_____	_____	_____
_____	_____/_____/_____	_____	_____

<u>DOES ANYONE IN YOUR FAMILY HAVE:</u>	<u>RELATIONSHIP TO CHILD</u>
DIABETES _____ YES _____ NO	_____
ALLERGIES/ASTHMA _____ YES _____ NO	_____
HEART DISEASE _____ YES _____ NO	_____
KIDNEY DISEASE _____ YES _____ NO	_____

ARE THERE ANY OTHER DISEASES THAT "RUN IN THE FAMILY?" _____ YES _____ NO
IF YES, PLEASE EXPLAIN: _____

CHILD'S MEDICAL HISTORY:

HAS YOUR CHILD HAD:

MEASLES	_____ YES	_____ NO
GERMAN MEASLES	_____ YES	_____ NO
MUMPS	_____ YES	_____ NO
CHICKEN POX	_____ YES	_____ NO
RHEUMATIC FEVER	_____ YES	_____ NO
OTHER (S): _____		

**Mental Health Provider: _____ Phone: _____

WHERE THERE ANY COMPLICATIONS FROM ANY OF THESE DISEASES? ___ YES ___ NO

IF YES, PLEASE EXPLAIN: _____

DO YOU CARRY FAMILY MEDICAL/ HOSPITAL INSURANCE? _____ YES _____ NO

NAME OF CARRIER: _____

POLICY/ GROUP #: _____

PHYSICAL CONDITIONS:

DOES YOUR CHILD HAVE ANY PHYSICAL CONDITIONS WHICH WOULD INTERFERE WITH CAMP ACTIVITIES? _____

DOES YOUR CHILD USE: BRACES: _____ WALKER: _____ WHEELCHAIR _____

DOES YOUR CHILD EXPERIENCE SEIZURES: _____ YES _____ NO

IF YES, ARE THEY CONTROLLED BY MEDICINE? _____

WHAT TYPE OF MEDICATION? _____

DOSAGE: _____

DOES YOUR CHILD WEAR GLASSES? _____ HEARING AIDES? _____

WILL YOUR CHILD REQUIRE MEDICATION DURING CAMP HOURS? _____

(IF YES, PLEASE DISCUSS WITH CAMP DIRECTOR/ NURSE)

MEDICATION: _____ DOSAGE: _____

HOW MANY TIMES DAILY: _____

IF FEMALE, HAS YOUR CHILD BEGUN MENSTRUATION? _____

BONES, JOINTS, MUSCLES, SKIN:

DEFORMITIES, SWELLING: _____

REDNESS OR TENDERNESS: _____

SCARS, ABRASIONS OR SORES: _____

LIMITATION OF MOTION, COORDINATION: _____

IMMUNIZATIONS:

MUST BE UP TO DATE – SEE ATTACHED FORM

ALLERGIES:

**TEACHER'S STATEMENT
FOR
LYNN SPECIAL NEEDS CAMP
RECREATION CENTER FOR CHILDREN WITH SPECIAL NEEDS
(TO BE FILLED OUT BY CHILD'S CURRENT TEACHER)**

CHILD'S NAME: _____
**IN AN EFFORT TO PROVIDE EACH CHILD WITH THE OPPORTUNITY OF EXPERIENCING
A CONTINUOUS EDUCATIONAL PROGRAM, PLEASE MAKE SUGGESTIONS IN THE
FOLLOWING AREAS FOR THE ABOVE MENTIONED CHILD SO THAT WE MAY
UNDERSTAND WHAT LEVEL THE CHILD IS AT WHEN WE PALN OUR RECREATIONAL
ACTIVITIES.**

GROSS MOTER SKILLS: _____

FINE MOTER SKILLS: _____

SELF-HELP SKILLS: _____

SENSORY SKILLS: _____

SOCIAL SKILLS: _____

COMMUNICATION SKILLS: _____

FUNCTIONAL ACADEMIC SKILLS: _____

BEHAVIOR MANAGEMENT TECHNIQUES: _____

ADDITIONAL COMMENTS (USE BACK IF NECESSARY): _____

TEACHER'S SIGNATURE: _____ **DATE:** ____/____/____

CLASS: _____ **SCHOOL:** _____

CITY/TOWN: _____ **PHONE NUMBER:** () _____