AFTER SCHOOL PROGRAM APPLICATION
Adams County

Easterseals Western and Central PA and Under the Horizon are pleased to be partnering to offer an after school program for individuals ages 8-21 with disabilities in Adams County. The program will operate on Tuesdays and Thursdays from 3– 6 pm from January 2019—May 2019.

This program will be both fun and educational for all who participate. **There are 16 spots** available so please be sure to register early. The fee is $5 per night. You must register by the month. Please note that all registrations for the January start are due by the 15th of December, and the rest of the months will follow the same pattern (registrations due the 15th of the month prior).

Individuals needing 1:1 behavioral support as well as those with a fragile medical condition will be required to have a non-parental support person over the age of 18 at the program. This could include a home nurse, TSS, etc… Easterseals provides an overall minimum staff to camper ratio of 1:4.

TO REGISTER:

Please send completed application via e-mail, fax, or standard mail to:

Virginia Anderson

E-Mail: vanderson@eastersealswcpenna.org

Fax: 717-741-5359

Mail: 2550 Kingston Rd. Suite 219, York, PA 17402

QUESTIONS?

For Registration or program information:

Virginia Anderson– vanderson@eastersealswcpenna.org (717) 741-3891

For studio information:

Cathleen Lerew - cathleen@underthehorizon.net (717) 752-4593

easterseals
Western & Central Pennsylvania

OFFICE USE ONLY

Application for After School Program

Easterseals Western & Central PA offers quality programming. In order to care for our clients, we ask that you complete all questions on this application thoroughly and accurately. Thank you!

Please return the completed application to Easterseals via e-mail, fax, or standard mail:

Attn: Virginia Anderson
E-mail: vanderson@eastersealswcpenna.org **Fax:** 717-741-5359 **Mail:** 2550 Kingston Rd. Suite 219, York, PA 17402
For questions, call 717-741-3891 or email vanderson@eastersealswcpenna.org

PARTICIPANT INFORMATION

Child's Name: _____ **Date of Birth** ____/____/_____ **Age:** _____ **Sex::** _____

Address: _____ **Home Phone Number:** (_____)_____

City, State Zip: _____ **County:**_____ **Race :** _____

Parent(s)/Guardian(s) Name(s): _____

E-mail: _____

Mother's Cell Phone: (____)_____ **Father's Cell Phone:** (____)_____

Mother's Work Phone (____)_____ **Father's Work Phone:** (____)_____

School District: _____ **School Building:** _____

School Building Address: _____

MILITARY SERIVCE - Is the participant or an immediate family member a current service member or veteran? YES NO

If yes, please list branch: _____ **Please circle one:** ACTIVE DUTY NATIONAL GUARD RESERVES VETERAN

Service member's relation to the participant:_____

EMERGENCY CONTACT– In the event that a parent/guardian cannot be reached, please list an alternate contact

Name: _____ **Relationship to Client:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

AUTHORIZATION OF PICK UP - Please list who is able to pick up the participant (other than parent/guardian)

All person picking up a participant will be required to show photo ID.

1) Name: _____ Relationship to Camper:_____
Home Phone: (____)_____ Cell Phone: (____)_____

2) Name: _____ Relationship to Camper:_____
Home Phone: (____)_____ Cell Phone: (____)_____

3) Name: _____ Relationship to Camper:_____
Home Phone: (____)_____ Cell Phone: (____)_____

4) Name: _____ Relationship to Camper:_____
Home Phone: (____)_____ Cell Phone: (____)_____

5) Name: _____ Relationship to Camper:_____
Home Phone: (____)_____ Cell Phone: (____)_____

PARTICIPANT PROFILE: This information will be used to ensure the participant's needs are adequately met. Please answer openly and completely. All information is confidential. *Use extra paper if necessary*. PLEASE answer all questions.

RATIO OF CARE that will best suit the camper (Circle) **1:1** **2:1** **3:1** **4:1 or higher**

Participants who require a 1:1 or 2:1 ratio for behavioral or medical reasons must be accompanied by a non-parental caregiver at all times. Please see the application cover page for additional information. ESWCPA does not provide one-on-ones for participants registered in after school programs.

CONDITION/DIAGNOSIS

1) Participant's primary diagnosis _____

Please note the participant's level of intellectual disability (if applicable) Mild Moderate Severe Profound

2) List any other disabilities/illnesses _____

3) Does this participant use: **(Circle any that apply)**

Crutches	Never	Sometimes	Often	Always			
Walker	Never	Sometimes	Often	Always			
Manual Wheelchair	Never	Sometimes	Often	Always-------	Independent	or	Needs Assistance
Electric Wheelchair	Never	Sometimes	Often	Always-------	Independent	or	Needs Assistance
Other _____	Never	Sometimes	Often	Always			

SPEECH AND LANGUAGE

1) Does the participant understand verbal communication ? YES NO

If NO, please describe the methods of communication that work best _____

_____

2) The participant express his/her needs by: (please check all that apply, and describe below)

☐ **Talking Clearly** ☐ **Talks with difficultly** ☐ **Gestures** ☐ **ASL/Signed English** ☐ **PECS/Communication Device** ☐ **Other**

Please describe _____

BEHAVIOR/ PERSONALITY/ SOCIALIZATION

1) Please rate the participant's behavior in the area described by each of the following words/phrases using the scale

1= ALWAYS 2 = FREQUENTLY 3 = SOMETIMES 4 = SELDOM 5 = NEVER

_____ Friendly towards others
_____ Enjoys helping others
_____ Shares or cooperates with others
_____ Willing to try new things
_____ Easily becomes involved in activities
_____ Accepts rules easily; complies with requests
_____ Focuses attention long enough to enjoy recreational and leisure activities
_____ Goes along with change in daily routines
_____ Participates in large group activities without demanding attention or being disruptive
_____ Accepts correction and can be redirected towards more appropriate behavior
_____ Behaves rudely/inappropriately towards others

_____ Excessive motor activity
_____ Acts without thought of consequences to self or others
_____ Inappropriate sexual behavior
_____ Avoids social contact with adults and peers
_____ Wanders from group situations
_____ Aggression without apparent cause
_____ Talks about something that is strange, frightening or disgusting
_____ Behavior puts self or others in danger of injury
_____ Temper outburst
_____ Seems unhappy or sad

Please attach additional sheet(s) if needed

2) Describe any unusual behaviors or behavior issues that we might expect to see and describe ways to handle them:

_____

_____

ACTIVITY RESTRICTIONS:

1) Are there any physical conditions, past operations or injuries which might restrict his/her participation in activities?
YES NO If yes, explain: _____

2) Does the camper know how to swim? YES NO

PARTICIPANT PROFILE CONTINUED

TOILETING

1) What is the participant's independence level during toileting? (Please circle)

Independent Needs Reminders Only Needs Some Assistance Needs Total Assistance

If participant needs reminders or some assistance with toileting, please indicate in what areas:

_____ Getting on/off toilet _____ Clothing _____ Wiping _____ Hand washing

_____ Needs Reminders—Please specify _____

2) Does the participant use/wear Depends/Diapers throughout the day? YES NO

**Please note - the camper is responsible for bringing their own depends/diapers.

3) Does the participant use a catheter? YES NO

Type of Catheterization used: _____

4) Does the participant have any behavior-related or disruptive toilet habits? YES NO

If yes, please describe: _____

EATING:

1) Does the participant need any assistance during eating? YES NO

If yes, please describe: _____

2) Does the participant have any dietary restrictions or food allergies? YES NO

If Yes, describe: _____

(If the camper has very specific dietary restrictions, please use addition paper to describe in detail)

QUESTIONS FOR THE PARTICIPANT: Please have the participant answer these questions.

1) My favorite food is: _____ **2) My favorite color is:** _____

3) I like to: _____

4) I know a lot about: _____

5) Some things that I like to do with my friends are: _____

6) My favorite kind of music is: _____

7) I really don't like it when: _____

8) I am worried about: _____

9) If I am upset I will: _____

10) To calm down, I: _____

11) When I need a break I will: _____

12) When I have free time I like:

_____ **Board Games** _____ **Drawing/Coloring** _____ **Craft Projects** _____ **Puzzles**

_____ **Sports** _____ **Singing** _____ **Reading** _____ **Listening to Music**

_____ **Walking** _____ **Writing** _____ **Other:** _____

PARENTS/CAREGIVERS - Please tell us any additional information about your child that can help us make this program the best possible experience for him/her. Please use additional paper if necessary.

Your Name: _____ **Relationship to Participant:**_____

_____

_____

_____

PARTICIPANT HEALTH HISTORY

Health History

1) How would you assess the camper's current health? (circle) GOOD FAIR POOR
2) List any chronic health problems and treatments that the camp health staff should be aware of (i.e. asthma, pressure sores, cough, constipation): _____
3) Has there been any recent exposure to a contagious disease? YES NO If yes, please explain: _____
4) Is the applicant a carrier of any infectious condition? YES NO If yes, please explain: _____
5) Does the camper have any known allergies? YES NO
   If yes, describe the allergy and the reactions:_____
   _____
6) Does the camper have (or a history of) seizures? YES NO If yes, please answer the following questions:
   Type:_____ Frequency: _____
   Duration: _____ Date of last Seizure: _____ Current Status (i.e. active, controlled): _____
   Describe typical recreations before, during and after seizures: _____
   _____
   Steps of action by staff: _____
7) Does the camper have diabetes? YES NO If Yes, how it is managed? _____
8) Has the camper been hospitalized or treated in the emergency room during the last year? YES NO
   If yes, explain: _____
9) Are there any physical conditions, past operations or injuries which might restrict his/her camp activities? YES NO
   If yes, explain: _____

Care Providers

Name of Primary Physician_____ Phone (_____)_____

Name of Dentist/Orthodontist_____ Phone (_____)_____

Name of Specialist(s)/ _____ Phone (_____)_____

_____ Phone (_____)_____

Insurance Carrier _____ Policy or Group # _____

PLEASE ATTACH A COPY OF INSURANCE CARD (BOTH SIDES)

Over The Counter Medications

Please indicate (checking Yes or No) for each of the following medications which can be used for the participant in a first-aid situation.

YES	NO	MEDICATION	YES	NO	MEDICATION
		Triple Antibiotic Ointment			Sunscreen
		Bacitracin Ointment			Insect Repellent
		Hydrocortisone Cream			Petroleum Jelly
		Ibuprofen/Advill Tablets			Tums
		Tylenol (Acetaminophen) Tablets			

Has your camper ever had an allergic reaction to any insect sting/bite? ____YES ____NO
If Yes, what was the reaction? _____

Prescription Medications

If the participant will need to take prescription medication while at the program, please complete the Medication Form that is included in this packet. All medications should be brought in their original containers, labeled with the participant's name.

Parent/Guardian or Applicant Agreement, Consent, and Release:

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING, and be aware that in signing up and participating in this program, and using the facilities and equipment, you will be waiving and releasing all claims for injuries or loss or property damage that you (or your child) might sustain arising in any manner out of this program or the use of the facilities or equipment. This section must be filled out and signed by each participant (or their parent/guardian) or they will not be allowed to participate or use the facilities or equipment.

Acknowledgement of Risk or Injury Clause- As a participant in the program, I recognize the risk and acknowledge that there are certain risks of physical injuries, including death, damages, property damage, or loss which I (or my child) may sustain as a result of participating in any and all activities connected with such program or the use of the facilities or equipment.

Permission to Treat - I hereby give permission for my child/ward to receive first aid from program staff. I hereby give permission to the medical personnel selected by Easterseals Western and Central Pennsylvania to order x-rays, routine tests, treatment and necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Easterseals Western and Central Pennsylvania to secure and administer treatment, including, but not limited to x-rays, hospitalization and surgical interventions. I also give permission to Easterseals Western and Central Pennsylvania to obtain related transportation. I recognize and acknowledge that there are certain risks of physical injury to participants in this program, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation.

Waiver of Claim for Injury Clause- I agree to waive and relinquish all claims that I (or my child) may have for injuries or damages, as a result of participating in the program or using the facilities or equipment, against Easterseals Western and Central Pennsylvania, Inc. and Easterseals Inc., and their officers, agents, servants, employees, and affiliates.

Policy Verification– Upon registration I understand that I am responsible for making sure that registrant is picked up promptly by 6:00 PM each evening. I agree to forfeit the registrant's slot if payment for the program is not made in full by the 15th of the previous month. For participants with a third party payer, all details must be agreed upon with ESWCPA prior to final registration. Additionally we acknowledge and understand that it is at the discretion of ESWCPA to require a 1:1 and at any time may terminate participation.

Release from Liability Clause-I do hereby fully release and discharge National Easterseals and Easterseals Western and Central Pennsylvania Inc., and their officers, agents, servants, employees, and affiliates from any and all claims for injuries, including death, damages, property damage, or loss which may have or which may in the future accrue to me (or my child) on account of participation in the program or use of the facilities or equipment.

Indemnity and Defense Clause- I further agree to indemnify and hold harmless and pay defense costs and defend National Easterseals, Easterseals Western and Central Pennsylvania Inc., and their officers, agents, servants, employees, and affiliates, from any and all claims resulting from injuries, including death, damages, property damage, or loss sustained by me (or my child) and arising out of, connected with, or in any way associated with the activities of the program or the use of faculties or equipment. The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Program Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. The undersigned recognizes the right of the Program Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medial actions which might jeopardize the participant's or others' health, safety, or well being at camp.

Signature: _____ **Date:** _____
(Signature of Parent/Guardian if participant is under the age of 18)

Photographic/Media Release:

_____ I hereby authorize and give my consent to Easterseals Western and Central Pennsylvania to photograph/video me or my child/ward, and without limitation, to use such photographs/video in connection with promoting/advertising the services, programs, and facilities of Easterseals Western and Central Pennsylvania without consideration of any kind. I understand that photos and/or video usage could include Easterseals Western and Central Pennsylvania's website, Facebook, and/or other social media outlets.

_____ I DO NOT authorize the use of photography/video of me or my child/ward by Easterseals Western and Central PA.

Signature: _____ **Date:** _____
(Signature of Parent/Guardian if participant is under the age of 18)

Payment Policy Agreement:

Camp fees must be paid in full prior to camp attendance, unless prior arrangements have been made and agreed upon. If the camper is using a 3rd party payer source and that payer source does not pay the bill, parents/guardians or participant will be responsible for the camp fee.

Signature: _____ **Date:** _____
(Signature of Parent/Guardian if participant is under the age of 18)

PROGRAM SELECTION

The after school program will run every Tuesday and Thursday. You must sign up by the month. The cost of the program is $5 per day. All program fees must be paid in full by the 15th of the month prior to attendance unless prior arrangements are made .

Please select the months that you would like to attend:

___ JANUARY 2019 ($45 - 9 days - Jan. 3, 8, 10, 15, 17, 22, 24, 29, 31)

___ FEBRUARY 2019 ($40 - 8 days - Feb. 5, 7, 12, 14, 19, 21, 26, 28)

___ MARCH 2019 ($40 - 8 days - March 5, 7, 12, 14, 19, 21, 26, 28)

___ APRIL 2019 ($40 - 8 days - April 2, 4, 9, 11, 16, 23, 25, 30)

___ MAY 2019 ($40 - 8 days - May 2, 7, 9, 14, 16, 21, 23, 28)

PAYMENT INFORMATION

Program fees must be paid by the 15th of the month prior to participation. We understand that if another agency is paying, they might not remit payment until after the program is complete. If this is the case we ask that you verify with a case manager or the payer source that the funds are available. If you attend the program and you do not have sufficient funds you will be personally responsible for the program fees.

How are the program fees to be paid?

_____ Self/Parent/Guardian

_____Check _____Cash or Money Order _____Credit Card (see below)

Type of credit card: __VISA __MASTERCARD __AMERICAN EXPRESS __ DISCOVER
Amount to be Charged: $_____ Name on Card:_____
Credit Card #: _____
Expiration Date: ____/_____ Security Code: _____

_____ Waiver Funds (see below)
_____ Family Driven Funds (see below)
_____ Other (see below)

Please fill out the information below if another agency is paying:

Organization: _____ Contact Name_____
Phone: _____ Email: _____
Address: _____

How much of the program fee will the organization be paying? $_____

ADDITIONAL INFORMATION

PICK UP POLICY

The program will end at 6:00 PM each day. Please pick your child up by 6 PM. A late pick-up fee system in place if you do NOT pick-up your camper by 6:00 PM.

FEE STRUCTURE FOR LATE PICK-UP

6:00 PM- 6:15 PM-$15 charge

6:15 PM- 6:30 PM-$30 charge

After 6:30 PM-$50 charge

These charges are per incident. Therefore, please be prompt will the 6:00 PM pick up. Referring to a standard school policy, we ask our parents/guardians to pick-up their child if he/she is sick. The camper MUST be free of a fever for a 24-hour time span before returning to the program.

If your camper's one-on-one/TSS/Nurse is absent, the participant **CANNOT** attend the afterschool program for that day.

We appreciate your cooperation. If there are any emergencies or late drop-off/pick-up, you will be provided with a number to call.

I, (please print name) _____, agree to the policies listed above for the Adams County After School Program for 2019.

Signature: _____ Date: _____

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Western & Central Pennsylvania

Easterseals Therapeutic Recreation Programs
Medication Form

Participant Name: _____

Please list all medications the participant is to receive at the program, including 'as needed' medication.

Permission to Administer Medication: I give permission to Easterseals to administer medication to me/my child as stated below. (Signature should be of parent/guardian if participant is under 18 or if a guardian is the legal power of attorney over participant.)

Signature: _____ **Date:** _____

Medication #1

Medication & Dose	Times Given	___/___	___/___	___/___	___/___	___/___	___/___	___/___

Route (i.e. by mouth, topical, etc.): _____

Medication #2

Medication & Dose	Times Given	___/___	___/___	___/___	___/___	___/___	___/___	___/___

Route (i.e. by mouth, topical, etc.): _____

Medication #3

Medication & Dose	Times Given	___/___	___/___	___/___	___/___	___/___	___/___	___/___

Route (i.e. by mouth, topical, etc.): _____

Medication #4

Medication & Dose	Times Given	___/___	___/___	___/___	___/___	___/___	___/___	___/___

Route (i.e. by mouth, topical, etc.): _____