Camper's Information

Child's Name_____ Nickname _____

Date of Birth_____/_____/_____ Sex: Male Female

Home Phone_____

Address_____

City_____State_____Zip_____

Parents Information

Parent's Name_____Occupation_____

Home Phone _____Cell Phone_____

Work Phone _____ Email_____

Parent's Name_____Occupation_____

Home Phone _____Cell Phone_____

Work Phone _____ Email_____

Legal Guardian, *if applicable* _____Phone Number_____

Primary Caregiver_____Phone Number_____

In case of emergency, if you cannot be reached, Camp Super Kids may contact:

Name_____Phone Number_____

Relationship_____

Medical Information

Primary Care Physician_____Phone #_____

Diagnosis_____Date of Diagnosis_____

Current Medications (Type & Dosage)_____

Allergies_____

Status of vision and hearing_____

Any devices used_____

Has your child had Botox or surgery? If yes, when? _____

Specialist	Doctor/ Location	Date of last visit	Tests given /Results/ Recommendations/Next appointment
Neurology			
Orthopedics			
Hearing			
Vision			
Other			

THERAPY SERVICES: (Please enclose current reports in application)

	Dates or Days of Services	Therapist & Location	Therapy Frequency
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Other (craniosacral, vision, hippotherapy, etc.)			

ACTIVITIES OF DAILY LIVING: ***Based on your observations rate the following:***

Activity	Completely independent	Needs supervision or prompting	Completes 75% of task	Completes 50%of task	Completes 25% of task	Dependent	Comment
DRESSING							
Coat							
Dress							
Pants							
Shirt							
Shoes							
Socks							
Underwear							
Efficiency_____mins. taken to dress			Adaptive equipment used:				
UNDRESSING							
Coat							
Dress							
Pants							
Shirt							
Shoes							
Socks							
Underwear							
Efficiency_____mins. taken to dress			Adaptive equipment used:				
FASTENERS							
Button							
Unbutton							
Zip / Unzip							
Tie bow							
Untie bow							
Efficiency: _____mins. taken to dress			Adaptive equipment used:				
SELF-CARE							
Blow nose							
Bathe self							
Brush teeth							
Comb hair							
Toilet self - bladder							
Toilet self - bowel							
Wash hands							
Adaptive equipment used:							
FEEDING							
Cut food w/ knife							
Drink from cup							

Name of Camper: _____ **Date**____/____/_____

Functional goals to be addressed at Camp:

1. _____

   _____

2. _____

   _____

3. _____

   _____

4. _____

   _____

5. _____

   _____

Financial Responsibility Form

Camper's Name: _____ Date of Birth_____/_____/_____

Guarantor for this account: _____ Date of Birth_____/_____/_____

Relationship to patient: _____

Home Phone _____Cell Phone_____

Work Phone _____ Email _____

Address_____

City_____State_____Zip_____

Check one:

_____ I will be paying for camp, do not bill insurance

Payment is due on the following dates:

- Submitted with registration form, $1000
- 6/15/18 $1000
- 6/29/18, $1000

_____ Bill insurance

Insurance Company_____

Address_____

City_____State_____Zip_____

Name of policy holder_____Relationship to patient _____

Policy holder's birthdate_____/_____/_____ Policy holder's Employer_____

Policy #_____ Group #_____

Kidnectivity will verify the patient's insurance benefits if we are billing insurance, but this verification is not a guarantee of payment. The guarantor (either the patient or person named) is responsible for payment of any and all balances on the account (copays, coinsurance amounts, visit charges not covered by insurance, and missed appointment charges.) If you have any questions regarding your insurance coverage, please contact the insurance company for clarification. If you have any other questions regarding billing and insurance, please contact our office at 847-784-8733.

As guarantor for this account, I acknowledge my responsibility for payment on this account.

_____ _____

Guarantor Signature **Date**

Please indicate which of the following your camper will participate in

_____ Pre-camp Constraint Class (Separate registration form required)

- Log constraint hours in a group class at Kidnectivity prior to camp
- Dates and times TBD
- We can bill insurance or you can pay out-of-pocket
- We will need a prescription from your doctor to create the constraint and participate if billing insurance.

_____ Physical Therapy during camp

- If we are billing your insurance we will bill them for PT
- Your prescription for camp will need to list both OT & PT
- If you are paying out of pocket, the cost of PT is already included

_____ After camp Yoga and Core Power classes (Separate registration form required)

- Monday, Wednesday & Friday's
- 12:00pm-2:30pm (Immediately following camp)
- We cannot bill insurance for these classes
- Camper's bring their own lunch from home