RECREATION DEPARTMENT

388 PLEASANT STREET, SOUTHINGTON, CT 06489
RECREATIONDEPT@SOUTHINGTON.ORG; (860) 276-6219
HTTPS://WWW.SOUTHINGTON.ORG/RECREATION

DAVID A. LAPREAY
Superintendent

D. J. VOISINE
Assistant Superintendent

JULIA BERARDINELLI
Administrative Assistant

CAMP RISE – SPECIAL NEEDS SUMMER CAMP
2025 PROGRAM APPLICATION

Camper Name: _____ ❑ Male ❑ Female

Nickname *(If Preferred)*: _____ Date of Birth: _____

Entering Grade Level - Fall 2025: _____ School: _____

Home Address *(Street, Town, Zip)*: _____

Parent/Guardian Name #1: _____

Phone: _____ Email: _____

Parent/Guardian Name #2 *(If Applicable)*: _____

Phone: _____ Email: _____

Hospital of Choice *(In the Event of an Emergency)*: _____

In the event of an emergency and the parent/guardian cannot be reached, please contact the following individual(s):

Name: _____ Relationship: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Name: _____ Relationship: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

YOU MUST NAME SOMEONE WHO IS REACHABLE DURING PROGRAM HOURS!

Primary Disability/Impairment _____

Please Indicate with a Check Mark if Applicable:

_____ Down Syndrome	_____ Cerebral Palsy	_____ Autism
_____ Speech/Language Disorder	_____ Visual Impairment	_____ Impulsive
_____ Hearing Impairment	_____ Touch Sensitive	_____ OCD
_____ Orthopedic Challenges	_____ Cognitive Delay	_____ ADD/ADHD
_____ Low Muscle Tone	_____ Developmental Delay	_____ Sign Language
_____ Transition Difficulty	_____ Social/Emotional Difficulty	_____ Epilepsy
_____ Self-Help Difficulty	_____ PDD	_____ Other

Please Explain Item(s) Checked Above:

_____

_____

_____

Asthma? _____ Yes** _____ No

***If yes, inhaler(s) MUST be provided DAILY and participant must be capable of self-administration under staff supervision. Inhaler remains in child's possession during the day.*

Details, for example, triggers (exercise, pollen, mold):

_____

Life-Threatening Allergy? _____ Yes** _____ No If yes, to what? _____

***Epi-Pen MUST be provided to activity leader and the enclosed "Parent/Guardian Authorization for the Town of Southington Recreation Department to Administer Epinephrine Injection" form MUST be completed (Part I, completed by Parent; Part II, completed by Physician).*

Medication(s)? _____ Yes _____ No

If yes, please list medications and any side effects of which staff should be aware:

_____

_____

Primary Care Physician _____

Health Care Insurance Company & ID # _____

Any restrictions at camp? (i.e. sun, heat, exercise, eating)

_____

_____

Any special needs during camp day? (i.e. physical assistance, rest periods, help with eating)

If participant is non-ambulatory, does he/she use a:

Wheelchair	_____ Yes	_____ No	Cane	_____ Yes	_____ No
Crutches	_____ Yes	_____ No	Arm/Leg Braces	_____ Yes	_____ No
Guide Dog	_____ Yes	_____ No	Walker	_____ Yes	_____ No

If you answered YES to any of the above, a conversation will take place with Camp RISE staff prior to the start of the program to determine how best to meet your child's needs.

Does your child have a 1:1 aide at school? _____ Yes _____ No

Does your child share an aide at school? _____ Yes _____ No

Is your child in mainstream class? _____ Yes _____ No

If YES, approximately what percentage of the academic day? _____

Is your child in alternative class or contained program? _____ Yes _____ No

Does your child receive support services at school? (PT, OT, Speech, etc.) _____ Yes _____ No

If YES, please explain: _____

PLEASE PROVIDE INFORMATION REGARDING THE FOLLOWING:

Fear(s), for example thunder, animals, loud noises, water, etc.:

What works best to calm/reassure participant in situations indicated above?

Communication skills (verbal, non-verbal, sign language, communication board, assistive technology):

Personality (i.e. shy, friendly/outgoing, tempermental, anxious, risk-taker, independent, hesitant, passive, quick to anger, distractible, etc.) and hints on how to best work with individual:

Eating/drinking limitations and/or habits:

Behavior patterns, transition suggestions, “triggers” that may lead to stress or anxiety, etc.:

Interests/Hobbies/Talents:

Challenges with fine motor, gross motor and/or self-help skills:

Please share any information not requested above which will be helpful to staff in providing a positive recreational experience:

NOTE: FAMILIES ARE REQUIRED TO PROVIDE DIAPERS & ALL PERSONAL CARE ITEMS

. . . . . .

FORM COMPLETED BY:

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

Date _____

CAMPER PICK-UP PERMISSION SLIP

(Form required only if someone <u>other than</u> parents/guardians will be providing transportation.)

CAMPER'S NAME (FIRST & LAST) _____

I, as parent or legal guardian of the above-named child, hereby grant permission for the individual(s) named below to pick up said child from the Camp RISE program at Derynoski Elementary School in the event that I (or another parent/guardian named on page 1 of the registration form) am unable to do so.

I understand that the individual(s) may be asked to present proper identification to a program staff member before being allowed to leave the school grounds with my child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

(Please print names clearly. <u>Do not</u> list parents/guardians already named on Page 1 of this form.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PHOTO/VIDEO PERMISSION SLIP

From time to time, the Recreation Department will take pictures and/or videos during camp activities. We would like your permission to use these images on our website, print materials and/or Facebook page and to share these images with those individuals and organizations who have donated funds to the Camp RISE program. Images would be selected to highlight fun activities during the camp day. We won't reference your child by name or provide any specific information regarding your child. The images will only be used to illustrate the many ways our campers are enjoying their summer.

Please take a moment to let us know your preferences regarding our use of photos/videos of your child:

_____ **YES** – I grant permission to the Town of Southington Recreation Department to use/share photos and/or videos of my child for the purposes outlined above.

-OR-

_____ **NO** – Please do not take, use or share any photos or videos of my child.

Child's Name (Print) _____

Parent/Guardian's Name (Print) _____

Parent/Guardian's Signature _____

Date _____

Please contact David Lapreay, Superintendent of Highway/Parks & Recreation, with any questions or concerns about this application form or the program in general.

By Phone: 860-276-6289 By Email: lapreayd@southington.org

Submit completed application packet (along with medical forms and payment) by mail or in person to:

Recreation Department
388 Pleasant Street
Southington, CT 06489

Registration Fee: $120.00 per child (Full 2-Week Program); or **$60.00 per child** (1 Week Only)

Checks Payable to "Town of Southington"

Submission Deadline: Monday, July 7, 2025

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2025 "CAMP RISE" SPECIAL NEEDS SUMMER CAMP
PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF
NON-PRESCRIPTION TOPICAL MEDICATIONS

I hereby request that the following non-prescription topical medication be administered to my child by the Town of Southington Recreation Department's "Camp RISE" Nurse.

I understand that I must supply the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions of the medication administration.

This authorization is limited to the following topical medications:

1. Ointments free of antibiotic, antifungal, or steroidal medications
2. Medicated powders
3. Gum or lip medications
4. Sunscreens

PLEASE PRINT:

Name of Child: _____ Date of Birth: _____

Address (Street, Town, State, Zip): _____

Name of medication: _____

Schedule of administration: _____

Site of administration: _____

Reason medication is being administered: _____

Medication to be administered from (date): _____ to (date): _____

Name of Parent/Guardian: _____

Telephone number(s): _____

I have administered at least one dose of the above medication to my child without adverse side effects.

_____ _____

Parent/Guardian Signature Date

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2025 "CAMP RISE" SPECIAL NEEDS SUMMER CAMP
PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF
IBUPROFEN OR ASPIRIN SUBSTITUTE CONTAINING ACETAMINOPHEN

Connecticut State Laws and Regulations allow licensed nursing personnel to administer ibuprofen or an aspirin substitute containing acetaminophen to a student with the written authorization of a parent or guardian on the form designated for this purpose. These medications are to be provided in the original, unopened, labeled containers and are to be delivered to the nurse by a parent, guardian or other responsible adult. Due to the possible incidence of Reye's Syndrome, **a student's private physician's order is required for the administration of aspirin**. Ibuprofen should not be given to aspirin sensitive or allergic individuals. Even though this product contains no aspirin or salicylates, a cross reaction may occur. **Ibuprofen may not be given to children under 12 years of age without a private physician's order.**

PLEASE PRINT:

Name of Child: _____ Date of Birth: _____

Address (Street, Town, State, Zip): _____

Condition for which medication is to be administered: _____

_____

Name of medication: _____

Amount of medication: _____

Time and/or frequency of medication: _____

History of known allergic reaction to this medication: _____

Medication to be administered from (date): _____ to (date): _____

Name of Parent/Guardian: _____

Telephone number(s): _____

I hereby request that the above medication be administered by the Town of Southington Recreation Department's "Camp RISE" Nurse to my child in accordance with State regulations. I understand that I must supply the camp with the above listed medication in the original labeled container and will provide no more than an eight (8) day supply of this medication.

I also understand that this medication will be properly destroyed if it is not picked up within one week following termination of this request or on the last day of the "Camp RISE" program.

_____ _____

Parent/Guardian Signature Date

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2025 "CAMP RISE" SPECIAL NEEDS SUMMER CAMP
PARENT/GUARDIAN AUTHORIZATION FOR THE TOWN OF SOUTHINGTON RECREATION DEPARTMENT TO ADMINISTER EPINEPHRINE INJECTION
(Part I and Part II must be completed before a child can participate in the program.)

PART I (To Be Completed by Parent/Guardian)

I, _____ parent/guardian of _____,
hereby give permission to any employee, contractor, or volunteer working for, or associated with the Town of Southington Recreation Department to assist in the administration of epinephrine injection(s) to _____ ONLY through use of a premeasured auto-injector (i.e. Epi-Pen) as directed by the physician in Part II below.

In giving permission to the Town of Southington Recreation Department to administer epinephrine injection(s), I hereby agree to the following:

1. I agree to indemnify, defend and hold harmless the Town of Southington, their officials, officers, employees, contractors, agents and/or volunteers from any liability whatsoever for any act or omission concerning the administration of the epinephrine injection to the child listed above including, but not limited to, the issues addressed in the following paragraphs.
2. I am aware that my child may be in the care of an individual with no medical training, and I understand that the injection could be administered incorrectly or may not be administered when medically appropriate. I assume the risk of delegating this responsibility to an individual who is not medically trained.
3. I understand and assume the risk that in the event that Part II of this form indicates that my child is competent and able to self-administer, my child will be permitted to carry the Epi-Pen throughout the program and will be free to determine whether to administer the Epi-Pen without direction or supervision by Recreation Department staff.
4. It is my duty to provide the Epi-Pen every time my child attends a program sponsored by the Recreation Department. If my child is not competent and able to self-administer, the Epi-Pen will be provided to the adult in charge in a secure container. The Epi-Pen will not be stored overnight by the Recreation Department.
5. It is my duty to insure the medication is labeled properly and has not expired.
6. It is my duty to insure that the Epi-Pen is functioning properly and does not need replacement.
7. I understand that only premeasured doses of epinephrine will be given. I understand that if the physician's orders include a repeat of the Epi-Pen injection, then two Epi-Pens must be supplied. I also understand that if the physician's orders change, I will provide the Recreation Department with an updated replacement for this form.

_____ _____
Parent/Guardian Signature Date

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2025 "CAMP RISE" SPECIAL NEEDS SUMMER CAMP
PARENT/GUARDIAN AUTHORIZATION FOR THE TOWN OF SOUTHINGTON RECREATION DEPARTMENT TO ADMINISTER EPINEPHRINE INJECTION

PART II (To Be Completed by Physician)

Name of Patient (Child): _____ Date of Birth: _____

Address (Street, Town, State, Zip): _____

Name of medication to be administered: _____

Dose of medication: _____

Frequency of administration: _____

The Epi-Pen injection will be given immediately after report of exposure to (indicate allergen and type of exposure, e.g. ingestion, skin contact, or inhalation):

_____

_____

Side effects to watch for:

_____

_____

Special instructions:

_____

_____

Is patient (child) competent and able to self-administer? ❑ Yes ❑ No

Printed Name of Physician: _____

Address: _____

Telephone Number: _____

_____ _____

Physician Signature Date

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AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICINE(S) BY TOWN OF SOUTHINGTON RECREATION DEPARTMENT "CAMP RISE" NURSE

Connecticut State Laws and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medication. Medication must be in pharmacy prepared containers and be labeled with the name of the child, strength, dosage, frequency, physician's or dentist's name, and date of original prescription.

Physician or Dentist's Order

Name of Patient (Child): _____ Date of Birth: _____

Address (Street, Town, State, Zip): _____

Condition for which drug is being administered during camp: _____

_____

Drug name, dose and method of administration: _____

_____

Time of administration: _____

Medication to be administered from (date): _____ to (date): _____

Relevant side effects and management: _____

_____

Is this a controlled drug? ❑ Yes ❑ No If Yes, DEA Number: _____

Printed Name of Physician/Dentist: _____

Address of Physician/Dentist: _____

Telephone Number: _____ Fax Number: _____

Signature of Physician/Dentist: _____ Date: _____

Permission of Parent or Guardian for Administration of Medication

I hereby request that the above medication, ordered by the physician/dentist for my child, be administered by the camp nurse at the "Camp RISE" Special Needs Camp. I understand that I must supply the camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than an eight (8) day supply of said medication. I understand that this medication will be properly destroyed if it is not picked up within one week following termination of the order or on the last day of the "Camp RISE" program.

Printed Name of Parent/Guardian: _____

Address (Street, Town, State, Zip): _____

Telephone Number(s): _____

Signature of Parent/Guardian: _____ Date: _____