



Rotary Camp Onseyawa Application

(Revised 02/2020)

Dear Parent, Guardian, Primary Care Provider:

The Rotary Clubs of Ontario, Seneca, Yates and Wayne Counties annually provide a cost-free overnight summer camping experience for children with disabilities at the end of August. Camp Onseyawa is held at Babcock-Hovey Boy Scout Camp in Ovid, NY. Camp Onseyawa serves campers between the ages of 8-16, with a wide variety of disabilities.

This year's camp dates are Monday, August 17th – Friday, August 28th.

Applications are due by June 1st, 2020.

For consideration by the Camp Onseyawa Selection Committee, a child must:

1. Be a resident of Ontario, Seneca, Yates or Wayne County, between the ages of 8 and 16 inclusive, as of August 1 of that year.
2. Have a handicap sufficiently severe to preclude admission to the average summer camp for children, but **NOT** involving:
 - a. Conditions requiring constant nursing care.
 - b. Communicable diseases in an infectious stage.
 - c. Behavior constituting a danger to self, others and/or property.
 - d. Acute illness (unless we have doctor's permission).
3. Be at least semi-ambulatory (use of wheelchair, braces, etc. is permissible).

Please read over the instructions and questions carefully. Please answer every question completely if it applies to your child. Please sign ALL releases as necessary. Failure to do these things and to return forms promptly will result in delayed processing and possible refusal of the application. Please return the Parent Forms, Free Lunch Form and Teacher Forms as soon as possible. We understand it may take longer for your physician to complete the medical form.

On the following page you will find instructions for completing the application. Please be sure to do every step! Don't be shy about asking questions. Call the Camp Onseyawa phone (315-585-6323), email (onseyawawa@gmail.com) or your local Rotary representative.

Please DO NOT call the Camp Babcock Hovey phone # in Ovid during non Camp dates!

You will be notified regarding the committee's decision after all applications have been reviewed. You should receive notification via email or mail by June 30th. Thank you for your help. We hope to see you this summer.



Application Instructions

_____ **1.** Complete "Camper Application Form" pages 1-5

- Pages 1-3: Camper Information
- Page 4: Signed Release Statements
- Page 5: Summer Food Service Program Form

_____ **2.** Attach a recent photo of your child to the application.

_____ **3.** Please send pages 1-5 of the "Camp Onseyawa Application" by mail or email. We do not have a fax during the off season.

Mail: Rotary Camp Onseyawa
Trish Brewer & Nicole Campbell
PO Box 614
Geneva, NY 14456
Email: onseyawa@gmail.com

_____ **4.** Make an appointment for a doctor's examination for your child as soon as possible. Give the "STATEMENT OF ATTENDING PHYSICIAN" form (cover page and 3 form pages) to the doctor to complete, sign, and return by June 1st. If you think your doctor needs more information about Camp Onseyawa or has requested information, please call the Camp Onseyawa Phone or send us an email.

_____ **5.** Give the "STATEMENT OF TEACHER OR CASEWORKER" form (cover page and 1 form page) to your child's teacher / caseworker to complete and return by June 1st. If they would like more information about Camp Onseyawa please call the Camp Onseyawa phone or send us an email.

If your camper(s) need medication(s) given while at camp, the medication(s) must come to camp in original container(s). The label must correctly state the medication, the dose and when it is to be given.

If there are any changes in medication(s) after the medical form is sent in, we must receive them in writing (with a doctor's signature) prior to opening day of camp.

In order to give even over-the-counter medications at camp, a doctor's order is necessary. Please have the doctor indicate on the medical form any over-the-counter medications you would like your child to receive during camp.

All forms must be completed and signed in order or your child to be accepted to Camp. **THE DOCTOR MUST SIGN & DATE ALL MEDICAL RELATED FORMS. THE FOOD SERVICE FORM IS REQUIRED**

The application should be received no later than June 1st, 2020.



ROTARY CAMP ONSEYAWA
Camper Application Form: PAGE 1

Name _____
First Last

DOB ____/____/____ Age this Aug. 1 ____ Sex ____ Height ____' ____" Weight ____ Shirt Size (Child/Adult) ____

How would you like to be notified? *Please check one or both.*

☐ Email (please make sure your email is listed below) **OR** ☐ Phone (____) _____

Email Address: _____
(VERY IMPORTANT PRINT CLEARLY)

Address _____
Address City/Town State Zip Code County

Name and relationship of Guardians(s) _____
First Last Relationship

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

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

List all others living at this address: _____

If child does **not** live with parents, give the name and address of a parent:

Name _____ Home Phone (____) _____

Address _____ Cell Phone (____) _____

City/Town _____ Zip code _____ Work Phone (____) _____

We will not accept a child without an additional contact person. Please list name and phone number of an additional person we can notify in case of an emergency -- *not a parent or legal guardian or the same phone as above:*

Name _____

Home Phone (____) _____ Cell Phone(____) _____



ROTARY CAMP ONSEYAWA
Camper Application Form: PAGE 2

Previous Camp Experiences:

Did your child attend Camp Onseyawa last summer? ☐ Yes ☐ No

If No, did you child ever attend Camp Onseyawa? ☐ Yes ☐ No

What was the most recent year? _____

Will your child attend any other camp this summer? ☐ Yes ☐ No

If yes, which camp? _____

Doctor Information:

Child's Doctor: _____ Hospital _____

Address _____
Address City / Town State Zip Code

Phone (_____) _____

What is your child's Medical Insurance? _____ Policy # _____

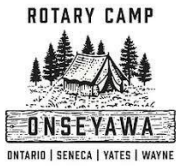
School Information:

What **school/agency** does your child attend? _____ Grade ____

Who is your child's social worker / caseworker? _____ Phone _____

What is your child's disability? _____

Please write down a brief description of your child's disability including any behavioral problems and any special needs he/she may have, which will help in the staff's understanding of your child.



ROTARY CAMP ONSEYAWA
Camper Application Form: PAGE 3

1. Does your child have seizures? ☐ Yes ☐ No

What date did the most recent seizure? _____

Describe a typical seizure. _____

On average, how many seizures does your child have per year? _____

2. Should your child have any activity restrictions at camp? ☐ Yes ☐ No

If yes, what do you recommend? _____

3. Are special rest periods, other than one in the afternoon, needed? ☐ Yes ☐ No

If yes, what do you recommend? _____

4. Does your child require wheelchair and/or other special equipment? ☐ Yes ☐ No

If yes, what is it? _____

Is there special care required for this equipment? (We recommend that, unless absolutely necessary to the child's welfare, "fancier", more expensive equipment be substituted with rugged, expendable equipment during the two weeks)

5. Does your child have bedtime concerns? ☐ Yes ☐ No

If yes, what is it? _____

6. Does your child have any allergies? ☐ Yes ☐ No

If yes, what are they? _____

7. Does your child have any special dietary needs? ☐ Yes ☐ No

If you answered yes, please specify:

☐ Celiac Disease ☐ Dairy Free ☐ Soy Free ☐ Wheat Free

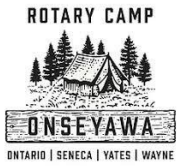
☐ Dye Free ☐ Other: _____

*Please submit Doctor's orders for special dietary requirements with this application.

Other comments or information you would like the selection committee and the staff to have about the needs of your child.

Rotary Camp Onseyawa participates in the "U.S. Surplus Food Program" and does not discriminate by race, color, national origin, sex, age, religion, or disability.

Rotary Camp Onseyawa is licensed by the Seneca County Department of Health and is required to be inspected yearly. Inspection reports are on file at the Seneca County Health Department and at the Camp Office.



ROTARY CAMP ONSEYAWA
Camper Application Form: PAGE 4

Releases: To be signed and dated by Parent(s) or Legal Guardian

Camper's Name: _____

Parent(s) or Legal Guardian (Please Print): _____

1. I/We understand that the entire expense involved will be borne by the camp and that no changes will be payable by or for such child. In consideration of this, I/we agree to hold the camp and its staff blameless for any and all claims, such as, by not limited to, loss of, or damage to, camper clothes personal articles, special equipment, and/or prosthetic devices.

Signature(s): _____ Date: _____

2. I/we also consent to allow the camp to use video & pictures and the name of my/our child for Public Relations.

Signature(s): _____ Date: _____

3. The health history is correct as far as I/we know, and the child described has my permission to engage in all prescribed activities, except as noted by myself (us) and/or the examining physician.

Signature(s): _____ Date: _____

4. I/We give permission for the prescription and over-the counter medication(s) signed off by child's Doctor or Nurse Practitioner to be administered by camp nursing staff as per the medication orders and/or camp application statement of attending physician form.

Signature(s): _____ Date: _____

5. I/We give permission for my / our child to engage in **regular/restricted** swimming activities under appropriate staff supervision (*Any restrictions should be indicated clearly on application*).

Signature(s): _____ Date: _____

6. In the event of an emergency, after every reasonable effort has been made to contact the parents or legal guardian and family doctor, I/we give my/our permission to the doctor, medical director or camp nurse selected by the camp director to provide whatever emergency medical treatment is needed.

Signature(s): _____ Date: _____

7. I/We give permission to the doctor whose name appears in the medical form and my/our child's teacher/case worker to release the information presented in PART II of this application to the camp. I also give camp administrators permission to contact the doctor, teacher and/or caseworker for additional information if necessary.

Signature(s): _____ Date: _____

8. _____ **will** be picking up my child on the closing day of each week.

Signature(s): _____ Date: _____

Home Phone: (____) _____ Cell Phone: (____) _____



**INCOME ELIGIBILITY FORM
SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)**

Please complete the following form using the instructions below. Sign the form and return it to: **[Name of Sponsor]**

If you need help, call **[phone number of Sponsor]**

Follow these instructions, if your household gets SNAP (Food Stamps) TANF or FDPIR:

Part 1: List participant's name and a SNAP (Food Stamp), TANF or FDPIR case number.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. A Social Security Number is NOT required.

Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:

Part 1: Enter the child's name.

Part 2: Please contact us at **[phone number of Sponsor]**

Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.

Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income from last month.

Column A--Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B--Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C--Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

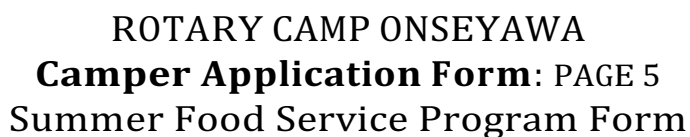
To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.



Part 1. Children enrolled in Camp or Closed Enrolled Sites.					
Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDIPIR case # (if any). Skip to Part 4 if you listed a case #.				
Part 2. Foster Child					
Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact [name of Sponsor] at [phone number]. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDIPIR case number in Part 1.					
Part 3. Total Household Gross Income—You must tell us how much and how often					
A. Name (List everyone in household, including children)	B. Gross income and how often it was received Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
2.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
3.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
4.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
5.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
6.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
7.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
8.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
9.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
10.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
11.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
12.	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
Part 4. Signature and Social Security Number (Adult must sign)					
An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) <i>I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.</i>					
Sign here: _____ Print name: _____ Date: _____					
Address: _____ Phone Number: _____					
Last four digits of Social Security Number: ____ _ □ I do not have a Social Security Number					
Part 5. Participant's ethnic and racial identities (optional)					
Mark one ethnic identity:	Mark one or more racial identities:				
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American				
Don't fill out this part. This is for official use only.					
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12					
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year					
Household size: _____					
Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____					
Reason: _____					
Determining Official's Signature: _____			Date: _____		
Confirming Official's Signature: _____			Date: _____		
Follow-up Official's Signature: _____			Date: _____		



ROTARY CAMP ONSEYAWA Statement of Attending Physician

(revised 02/2020)

Dear Physician,

The Rotary Clubs of Ontario, Seneca, Yates and Wayne Counties annually provide a cost-free summer camping experience for children with disabilities. Campers attend an overnight session of Rotary Camp Onseyawa in August. The camp is at Babcock-Hovey Boy Scout Camp in Ovid, NY. Camp Onseyawa serves campers between the ages of 8 and 16. The success of this camp for individuals with disabilities largely depends upon the camper. Those responsible for selection of eligible campers do not as a rule see the campers until after their arrival at camp.

It is exceedingly important therefore, that you answer all the following questions completely and candidly. *Please fill out the following 3 pages or send in a School Camp Form that contains ALL the same information and is dated for the 2020 school year.* You may be assured that all information will be kept in strict confidence. We will use the information only to help us in selection of campers and to provide adequate care during their time with us. **The selection committee will not accept a camper until all the forms have been received.** Please send completed form by June 1st, 2020 to:

Rotary Camp Onseyawa
Trish Brewer and Nicole Campbell
PO Box 614
Geneva, NY 14456
(315) 585-6323

Delay in processing the child's application and possible applicant refusal will result if this form is incomplete or ambiguous. We appreciate your cooperation in helping us select individuals who are able to participate in the activities of our summer overnight camping experience.

Sincerely,

Rotary Camp Onseyawa Selection Committee



ROTARY CAMP ONSEYAWA
Statement of Attending Physician: PAGE 1
Must be completed by the Doctor or Nurse Practitioner

PLEASE PRINT OR TYPE

Child's Name _____ Birthdate ____ / ____ / ____

Home Address _____ Phone (____) _____

Parents or Legal Guardian _____

Primary Handicapping Condition _____

Additional Diagnoses _____

Required Immunizations	Dates of 1st series			Dates of boosters	
	1st	2nd	3rd	1st	2nd
Td					
DPT					
Polio (oral / inj.?)					XXXXX
MMR			XXXXX	XXXXX	XXXXX
Hepatitis B					

Physical Restrictions:

Special Equipment:

Dietary Restrictions:

Allergies:

Medical/Surgical History:

Seizure History: ____Yes ____No

Type: _____

Description: _____

Special Exercises/Treatment:

Comments/Concerns:



ROTARY CAMP ONSEYAWA

Statement of Attending Physician: PAGE 2

Must be completed by the Doctor or Nurse Practitioner

Child's Name _____

The following is a list of over-the-counter medication available for dispensing at camp. Please indicate with a check mark if this patient may receive these medications.

- ☐ Acetaminophen 15mg/kg Q4hr PRN temp > 101 F, minor pain or discomfort.
- ☐ Acetaminophen 500mg tablets 1-2 tablets Q4hr PRN temp>101 F, minor pain or discomfort.
- ☐ Ibuprofen 200mg-400mg Q4-6hr PRN minor pain or discomfort.
- ☐ Robitussin DM 1-2 Tsp. PO Q6-8hr PRN coughing.
- ☐ Benadryl Elixir / capsule 15mg-25mg PO Q6-8hr (5mg/kg/24hr) PRN not to exceed 300mg/24hr, minor allergic reaction, severe puritis.
- ☐ Milk of Magnesia 15cc-30cc PO QD PRN constipation.
- ☐ Chloraseptic Spray PO Q2-4 hr PRN minor throat discomfort.
- ☐ Triple Antibiotic Ointment apply topically to affected area PRN minor cuts / abrasions.
- ☐ Caladryl lotion apply topically to affected area PRN minor itching.
- ☐ Kaopectate 30-60 ml PO PRN after each loose BM, not to exceed 6 doses/day or a period > 48hrs.
- ☐ "After Bite" (Ammonium Hydroxide) apply topically to insect bites PRN itching.
- ☐ Loperamide Hydrochloride 2mg Tablets/Capsules PRN after loose stools.
- ☐ May apply sunscreen to exposed areas.
- ☐ May use bug spray.
- ☐ Pepto Bismol 30ml every 1 hr. as needed for upset stomach.

NOTE: If there are any changes in medications or other medical information after this form is submitted, please notify the camp in writing.



ROTARY CAMP ONSEYAWA
Statement of Attending Physician: PAGE 3
Must be completed by the Doctor or Nurse Practitioner

Medications orders

If a child is to get any medications during Camp (including Over-the-Counter medications),
This form must be completed and brought to camp at Check-in.

- Medication(s) must be in original containers with clear, correct labels.
- No changes will be made without a Doctors/Nurse Practitioner's written order

_____ should receive the following medications at camp:
(Name of Child)

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

Medication _____
Strength (mg) _____
Dose _____
Frequency/Time to be given @ camp _____

☐ No prescription medication required.

Doctor's/ Nurse Practitioner's Signature _____ Date: _____

Doctor's/Nurse Practitioner's Name (*please print*): _____ Phone: _____



ROTARY CAMP ONSEYAWA

Statement of Teacher

(revised 02/2020)

Your student/client is submitting an application for attendance at Rotary Camp Onseyawa. We need your assistance in the camper selection process by providing as much and as accurate information as you are able regarding this child.

The Rotary Clubs of **Ontario**, **Seneca**, **Yates** and **Wayne** Counties annually provide cost-free summer camping experiences for children with disabilities. Campers attend an overnight session of Rotary Camp Onseyawa at the end of August. The Camp is held at Babcock-Hovey Boy Scout Camp in Ovid, NY. Camp Onseyawa serves campers between the ages of 8-16, with a wide variety of disabilities.

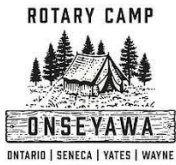
The success of this camp for disabled individuals largely depends upon the camper. Those responsible for selection of eligible campers do not as a rule see the campers until after their arrival at camp. It is exceedingly important therefore, that you answer all the following questions completely and candidly. You may be assured that all information will be kept in strict confidence and used only to help us in selection of campers who might benefit the most from our program and to assist us in providing the most appropriate programs for those who are selected. Upon completion of this form, please return it to the camp office as soon as possible, **but no later than June 1st, 2020**. Please send the completed form to:

Rotary Camp Onseyawa
Trish Brewer & Nicole Campbell
PO Box 614
Geneva, NY 14456
(315) 585-6323

The selection of campers in an efficient, organized and timely manner will be difficult if this form is incomplete, ambiguous or absent. **The selection committee will not be accepting campers until all forms are received.** We ask you to please take the time to fill out the form and return it, realizing very well that you have many such tasks to accomplish at this time of year. Your cooperation is much appreciated.

Sincerely,

Rotary Camp Onseyawa Selection Committee



ROTARY CAMP ONSEYAWA Statement of Teacher

Student's / Client's Name: _____

CSE Classification: _____ Ratio Students / Staff: _____ % day in Special Education setting: _____

Type of education program (i.e., center based, resource, regular grade, etc.) _____

Please complete each item below. **If applicable, please attach a current and specific behavior plan.**

1. Motor Ability

- ☐ Walks Independently
- ☐ Uses brace(s)
- ☐ Uses crutch(es)
- ☐ Uses a wheelchair

2. Eating Skills

- ☐ Eats independently
- ☐ Needs some assistance
- ☐ Needs total assistance

3. Dressing Skills

- ☐ Dresses independently
- ☐ Needs some assistance
- ☐ Needs total assistance

4. Toileting Skills

- ☐ Independent
- ☐ Needs to be reminded
- ☐ Needs some assistance
- ☐ Not toilet trained
- ☐ Uses catheterization techniques

5. Socialization

- ☐ Follows adult directions
- ☐ Shares/takes turns
- ☐ Plays with others
- ☐ Aggressive
- ☐ Withdrawn/Negative
- ☐ Has temper tantrums

6. Services Received

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Adaptive Physical Education
- ☐ Speech/Language Therapy
- ☐ Individual Counseling

7. Attention Span/Supervision

- ☐ Occupies self – unattended
- ☐ Occupies self – attended
- ☐ Needs constant supervision
- ☐ Has 1:1 supervision

reason: _____

8. Communication (Receptive)

- ☐ Does not show understanding
- ☐ Follows simple directions
- ☐ Follows complex directions

9. Communication (Expressive)

- ☐ Talks in sentence
- ☐ Mostly unintelligible
- ☐ Sometimes unintelligible
- ☐ Uses alternative mode

Home: _____

School: _____

10. Behavior Plans

- ☐ Uses reinforcers (list below)
- ☐ Uses time out (describe frequency and type below)
- ☐ Other _____

11. What are situations that can be frustrating or difficult for this child?

12. Teacher comments:

Name of Teacher or Caseworker please print): _____

Signature: _____ School Phone: _____

School/BOCES Program: _____