



2324 West 13th Street
Brooklyn, NY 11223

Please Attach
Current
Photo

Mini Day Camp Program Application

Date: _____

First Name: _____ Last Name: _____

Date of Birth: ___ / ___ / ___ Age: _____ Last Weight: _____

Address: _____ Cross Streets: _____

City: _____ State: _____ Zip Code _____

Home Phone #: (____) _____ - _____.

Parent's Marital Status: (circle) Married Divorced Single Widowed

Mother's Name: _____ Mother's Cell Phone #: (____) _____ - _____

Mother's Occupation: _____ Mother's Work Phone #: (____) _____ - _____

Mother's Email: _____

Father's Name: _____ Father's Cell Phone #: (____) _____ - _____

Father's Occupation: _____ Father's Work Phone #: (____) _____ - _____

Father's Email: _____

Emergency Contacts:

1. Name: _____ Phone #: (____) _____ - _____

Address: _____

Relationship to Child: _____

2. Name: _____ Phone #: (____) _____ - _____

Address: _____

Relationship to Child: _____

3. Name: _____ Phone #: (____) _____ - _____

Address: _____

Relationship to Child: _____

If emergency contacts are not available appropriate measures will be taken.

Doctor's Name: _____ Phone Number: (____) _____ - _____

Address: _____

Other Specialist Name: _____ Phone Number: (____) _____ - _____

Address: _____

Child's Medicaid #: _____ Child's SS #: _____

Health Insurance (other than Medicaid): _____

Policy #: _____ Policy in name of: _____

Child's Diagnosis: _____

Functioning Level: (circle) Mild Moderate Severe Profound

Please check all disabilities that apply;

Mental Retardation

Deaf

Epilepsy

Hearing Impaired

Autism

Vision Impaired

PDD

Mobility Impaired

Down Syndrome

Blind

Cerebral Palsy

Other: _____

What School Program does your child attend? _____

Address: _____

Contact Person: _____ Phone Number: # : (____) _____ - _____

Does your child have a medical condition for which he/she is being treated? ___ Yes ___ No

If yes, please list the condition and medication taken:

1. Condition: _____ Medication/ Dosage: _____

2. Condition: _____ Medication/ Dosage: _____

3. Condition: _____ Medication/ Dosage: _____

Does your child take his/her own medication? ___ No ___ Yes

Does your child have seizures? ___ No ___ Yes

If yes, what procedure should be followed?

List any allergies your child has: _____

Is your child toilet trained? ___ No ___ Yes

If yes, how much assistance do they need? _____

How does your child indicate the need to use the bathroom?

How does your child behave in a new environment?

What method works best in calming your child?

Please list some of your child's favorite activities:

If your child engages in any of the following activities please describe the behavior and circumstances:

1. Self-injurious behavior:

2. Injurious to others:

3. Self-stimulating behavior:

How does your child communicate? Verbally Sign Language Communication Board

What language(s) does your child speak and understand? _____

How much and what kind of assistance, if any, does your child need during mealtimes?

Is your child on a special diet? No Yes

If yes, please specify:

Is there any behavior we should be aware of during feeding time? Please specify:

Is your child enrolled in Medicaid Waiver: Yes No

Service Coordinator: _____ Phone # : (_____) _____ - _____ Ext. _____

Agency: _____

Address: _____