



# RESOURCES FOR EXCEPTIONAL CHILDREN AND YOUTH - Durham Region

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## APPLICATION FOR CAMP - ENHANCED STAFFING SUPPORT

### **Camp applications will only be considered under the following criteria:**

Please check appropriate criteria relating to your child. (*Statements are listed in order of priority for consideration*)

- Adult intervention is required to respond to the child's ongoing medical needs while attending a group setting.
- Additional adult supervision is absolutely essential due to the child's injurious behaviour to self or others and their lack of understanding of personal safety, which frequently puts them at risk. Consideration will be given to the frequency and severity of the behaviours.
- Child displays physical challenges that impact on their ability to participate in the routines and expectations of the program. Adult assistance with positioning, mobility and use of equipment in a group situation is required.

### **Support will not be approved for developmental or educational purposes.**

All sections of this application must be completed by the parent in order to proceed with approval process.

**Child's Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_  
(day/month/year)

Parent / Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Contact Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

**Name of Camp Program:** \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hours of Camp: \_\_\_\_\_

Dates/Weeks Attending: \_\_\_\_\_

Level of Support Needed: (Adult: Child/ren) 1:1 \_\_\_\_\_ or 1:2 \_\_\_\_\_

Diagnosis: \_\_\_\_\_ By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

**Brief description of need:**

**In order to evaluate the needs of the camp program, please respond to the following:**

**How does your child communicate?** *(Please check all that apply)*

- Verbally
  P.E.C.s/Visuals  
 Sign Language
  Other: (Please specify) \_\_\_\_\_

**Adult assistance is required to:** *(Please check all that apply)*

- Attend to the medical needs of the child e.g., Insulin, seizures  
*(please specify)* \_\_\_\_\_
- Assist with positioning, mobility, use of equipment  
*(please specify)* \_\_\_\_\_

**Equipment required at camp** *(please specify):* \_\_\_\_\_

**Compared to same age peers, high levels of adult assistance are required to:**  
*(please check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Follow simple directions/tasks | <input type="checkbox"/> Follow routines / schedules             |
| <input type="checkbox"/> Interact with peers            | <input type="checkbox"/> Transition from one activity to another |
| <input type="checkbox"/> Participate in swimming        | <input type="checkbox"/> Complete crafts / table tasks           |
| <input type="checkbox"/> Engage in fine motor tasks     | <input type="checkbox"/> Engage in gross motor tasks             |
| <input type="checkbox"/> Eat snack/lunch                | <input type="checkbox"/> Complete toilet routine                 |
| <input type="checkbox"/> Communicate wants/ needs       | <input type="checkbox"/> Dress                                   |

**Compared to their peers, my child:** *(please check appropriate box)*

	Constantly	Several times a Day	Occasionally
Displays frustration by crying, refusing to complete tasks			
Is unaware of personal safety; attempts to engage in unsafe activities			
Displays tantrums			
Needs extra time to settle			
Displays aggression towards adults or peers			
Is destructive of property including toys or furniture			

**What times of the day are the concerns most challenging?** *(please check times/activities)*

A.M.	P.M.
<input type="checkbox"/> Games/Sports	<input type="checkbox"/> Games/Sports
<input type="checkbox"/> Arts/Crafts	<input type="checkbox"/> Arts/Crafts
<input type="checkbox"/> Snack/Lunch	<input type="checkbox"/> Snack
<input type="checkbox"/> Outdoor/Gross motor	<input type="checkbox"/> Outdoor/Gross motor
<input type="checkbox"/> Washroom	<input type="checkbox"/> Washroom
Other: _____	<input type="checkbox"/> Swimming/Pool

**Are you currently accessing other funding sources?**

ACSD: Yes [ ] No [ ] amount: \_\_\_\_\_

SSAH: Yes [ ] No [ ] amount: \_\_\_\_\_

OTHER: Yes [ ] No [ ] amount: \_\_\_\_\_ Name of other funding: \_\_\_\_\_

Waitlisted	Receiving	PLEASE INDICATE SERVICES CURRENTLY WAITLISTED OR INVOLVED WITH:
		Durham Behaviour Management Services
		Kinark Child & Family Services
		Grandview Children's Centre
		Durham Preschool Speech and Language Program
		Resources for Exceptional Children And Youth – Durham Region Resource Consultant's Name:
		Other (Please list)_____

**Parent(s) are:**

Working: Full time \_\_\_\_\_ or Part time \_\_\_\_\_

Attending School: Full time \_\_\_\_\_ or Part time \_\_\_\_\_

**SIGNATURES:**

I/We hereby apply for Enhanced Staffing Support and declare that all sections have been completed and that the enclosed information is true to the best of my/our knowledge.

I/We are aware that the child and/or camp program must meet the specific criteria for the approval of support.

I/We understand that Resources for Exceptional Children and Youth - Durham Region will attempt to provide support that responds to the needs of the child and camp program and that is fair and equitable throughout the Region; however, limited resources may impact on approval of applications.

If the child is withdrawn from the designated camp program, this application becomes null and void.

I/We acknowledge that the Enhanced Staffing personnel will be required to contact the camp program to plan for the child's attendance, the provision of support and to share information contained on this application to ensure a successful camp experience.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

OFFICE USE:		
Application: Approved _____	Denied _____	Waitlisted _____
Date Parent Contacted: _____		