Achievement Center Use Only
Application Received
Date: ________________ Time: _________

LEADERS Summer Camp Application

Summer Therapeutic Activities Program (STAP)

<table>
<tr><td colspan="3">Child's Name:</td><td colspan="2">Date of Application:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td colspan="2">Social Security #:</td><td>☐ Male
☐ Female</td></tr>
<tr><td>Parent/Guardian's Name:</td><td colspan="4">Home Address:</td></tr>
<tr><td>Home Phone:</td><td colspan="2">Cell Phone:</td><td colspan="2">Work Phone:</td></tr>
<tr><td>Medical Assistance #:</td><td colspan="2">Private Insurance Company:</td><td colspan="2">Insurance Group #</td></tr>
<tr><td>School District:</td><td colspan="2">School Name:</td><td colspan="2">School Contact Person:</td></tr>
<tr><td>Other Service Involvement

☐ BHRS (BSC, MT or TSS)
☐ Out Patient Counseling
☐ Children and Youth
☐ Juvenile Probation
☐ Drug and Alcohol
☐ Other</td><td colspan="4">If you check any of these boxes to the left, please describe your child's involvement with that service in the space provided below:</td></tr>
</table>

<table>
<tr><td>Diagnosis:
☐ Autistic Disorder
☐ Pervasive Developmental Disorder (PDD-NOS)
☐ Asperger's Syndrome
☐ Other Mental Health Diagnoses (please list in space provided below)</td><td>Diagnosis Given By:

If Receiving BHRS – Date of Most Recent Medical Necessity Evaluation:</td></tr>
</table>

Describe Child's Strengths: List Child's Favorite Foods/Toys/Activities/Movies/Music:

In the next section, you will be asked to describe your child's current means of communication as well as his/her skill level with that particular mode of communication. Please check the box on the left that best describes how your child communicates and then check one of the four boxes to the left which describes how he/she uses that mode of communication.

☐ **My child speaks**	☐ Fully conversational	☐ Uses phrases and short sentences	☐ Uses 2-word phrases to request and label things	☐ Uses single words to make simple requests

☐ **My child uses sign language**	☐ Fully conversational with sign language	☐ Signs phrases and short sentences	☐ Signs 2-word phrases to request and label things	☐ Signs single words to make simple requests

☐ **My child uses PECS**	☐ Phase 4 (uses sentence strip to construct 3 to 4-word sentences to make requests)	☐ Phase 3 (can use pictures to request at least 10 items or activities)	☐ Phase 2 (can make the basic PECS transfer even when the adult is across the room)	☐ Phase 1 (can make the basic PECS transfer with adult directly in front of child)

☐ **My child uses assistive technology (a communication device)**	List the type of device your child uses as well as a brief description of how well he/she can use the device:

In the next section you will be asked to indicate which (if any) problem behaviors your child displays and how frequently he/she does so. If you check a box indicating that your child engages in a particular behavior, please make sure to check one of the four boxes to the right that indicates how often you see that behavior occur.

☐ **Check Here if Your Child Engages in No Problem Behavior**

☐ **Slapping or punching others**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Kicking others**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Grabbing, scratching or pinching others**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Biting others**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Head butting others**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Striking self**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Biting self**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Head butting property**	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

☐ **Severe tantrum***	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

*Severe tantrum would include incidents of screaming and/or dropping to the floor that last more than 5 minutes.

☐ **Elopement***	☐ Multiple times daily	☐ Once a day	☐ Multiple times per week	☐ Once a week	☐ Once a month

*Elopement would include running or wandering from adult supervision that places the child in danger and requires locked doors or other physical barriers to maintain safety.

Is Your Child Toilet Trained?

- ☐ Bladder Trained Only
- ☐ Bladder and Bowel Trained
- ☐ Wears Pull-ups
- ☐ Not Toilet Trained

In the next section, you will be asked to list all medications that your child receives *during the hours of camp* (9am-3pm)

MEDICATION	TIME OF DAY MED MUST BE GIVEN
1.	
2.	
3.	
4.	
5.	
6.	

Primary Care Physician:	
Known Allergies:	Special Dietary Needs:
Chronic Medical Conditions:	Physical Limitations:

What do you hope your child will gain from this camp experience?

What is your child's T-shirt size? (circle the size)
Child Small Child Medium Child Large

Adult Small Adult Medium Adult Large Adult Extra Large

I would prefer to attend parent meetings to discuss my child's progress:

- ☐ Weekly
- ☐ Every other week
- ☐ Twice during camp (midterm and final review)
- ☐ Not at all

Signature: ____ Date: _________________________

Relationship to child: ______________________________________

Please return completed application to:

Achievement Center
Attn: LEADERS Summer Camp – Robert Gulick
1611 Peach Street / Suite 270
Erie, Pennsylvania 16507