



Application for NEW Campers

Summer 2012
July 2 to August 3, 2012
Ages 5-11

* deadline for applications and payment: May 31, 2012
Daybreak is a small camp, applications accepted on a first-come, first-serve basis

M-F 8:30-2:30

Application checklist

Are all these forms complete?

- Parent/Guardian Referral** (3 pages)
- Professional Referral** (3 pages)
- Authorization and Information Release Forms** (2 pages)
- Tuition Information and CDBG Form** (2 pages)
- Parent's Health Form** (2 pages)
- Doctor Form** (2 pages including Medication Form)
Physical and immunization record dated after September 2010.
May be substituted by a signed print-out from the doctor's office.
- Food Form** (Front and Back of page)



Parent/Guardian Referral—New Camper

Daybreak Daycamp
99 BISHOP ALLEN DRIVE
CAMBRIDGE, MA 02139
PHONE: (617)864-0960

General Information

Child's Name _____ Date of Birth ____ / ____ / ____ Sex: **M** **F**

Address _____

CITY

ZIP

Parent/Guardian _____

Relationship to your child _____

Home Phone (____) ____ -- _____ Work Phone (____) ____ -- _____

Cell Phone (____) ____ -- _____

Does your child have any medical problems or physical disabilities? **Yes** **No**
If yes, please describe.

Is your child currently taking medication? **Yes** **No**
If yes, please describe.

Will the child need to receive medication during camp hours? **Yes** **No**
If yes, complete the MEDICATION FORM (page 15) and see the Daybreak Information Guide for information about administration of medication at camp.

School and Related Information

Name of Child's School _____ Grade Level _____

Name of Teacher _____

1. special education services? **Yes** **No**
If yes, please describe.

2. Does your child receive counseling services at school or in the community? **Yes** **No**
If yes, provide **Name of Agency** _____

Therapist, (or contact person) _____

Address _____

Phone (____) ____ -- _____

3. Name of person completing the **Professional Referral Report** _____
Relationship of this person to child _____

4. Has your child ever attended camp before? **Yes** **No** *If yes, which camp?* _____
How successful was this experience? Were there any difficulties?

Parent/Guardian Referral

Description of Child

1. What is your child especially good at?

At home:

At school:

2. What does your child have difficulty with?

At home:

At school:

3. How well does your child get along with other children?

4. Why does your child need a specialized camp setting?

Parent/Guardian Referral

5. List three things that you hope your child will gain from a day camp experience?

A. _____

B. _____

C. _____

6. Please check the behaviors that best describe your child.

- likes to be in a group
- wets pants/soils
- withdraws/daydreams
- easily frustrated
- anxious/fearful
- creative
- hyperactive
- follows directions
- sexually provocative

- swears
- friendly
- runs off
- lies/steals
- loud
- tries to hurt others
- talkative
- breaks things
- sense of humor

- shy
- affectionate
- screams
- disorganized
- teases other children
- respectful
- athletic

- has temper tantrums

7. What works best when your child is upset or having difficulty? Please be specific.

8. Does your child's behavior escalate to the point of needing physical restraint? If yes, how often does this occur? Please list any specific triggers for these incidents.

9. Is there any information about your child's history or family that you think would be helpful for staff members to know?

Please send completed reports to:



Daybreak Day Camp
Cambridge Camping
99 Bishop Allen Drive
Cambridge, MA 02139



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Professional Referral – New Camper

To be completed by a teacher, counselor, therapist or social worker

Daybreak Day Camp is a small summer program designed to meet the needs of children who may demonstrate emotional, social, or behavioral difficulties. This referral is part of an application process. It will help us learn about this child and determine whether our program can appropriately meet his/her needs. The camp director may contact you for additional information. Please note: The Parent/Guardian Referral Report must also be submitted before a child can be considered for the Daybreak program.

General Information

Child's Name _____ Date of Birth ____ / ____ / ____ Sex: M F
 Parent/Guardian _____ Telephone number (____) ____ --

Name of Referrer _____

Agency or School _____

Relationship to this child _____

How long have you known this child? _____

Does this child have any medical problems or physical disabilities that you are aware of? Yes No
If yes, please describe.

Is this child currently taking medication? Yes No
If yes, please list and describe.

Description of Child's Special Needs

1. Why does this child need a specialized camp setting? Please include any relevant diagnostic information.

2. What are this child's areas of strength or skill?

Professional Referral

3. What are this child's areas of weakness?

4. How does this child function in group settings?

5. Please rate the child's skills in the following areas:

Gross Motor Skills	Above Average	Average	Below Average
Fine Motor Skills	Above Average	Average	Below Average
Self Care Skills	Above Average	Average	Below Average
Language and Communication Skills	Above Average	Average	Below Average
Social Skills	Above Average	Average	Below Average

6. Has this child ever made self-destructive or suicidal gestures? Yes No

Please describe.

7. Please check the behaviors that best describe this child.

- | | | |
|---|---|--|
| <input type="checkbox"/> likes to be in a group | <input type="checkbox"/> swears | <input type="checkbox"/> shy |
| <input type="checkbox"/> wets pants/soils | <input type="checkbox"/> friendly | <input type="checkbox"/> affectionate |
| <input type="checkbox"/> withdraws/daydreams | <input type="checkbox"/> runs off | <input type="checkbox"/> screams |
| <input type="checkbox"/> easily frustrated | <input type="checkbox"/> lies/steals | <input type="checkbox"/> disorganized |
| <input type="checkbox"/> anxious/fearful | <input type="checkbox"/> loud | <input type="checkbox"/> teases other children |
| <input type="checkbox"/> creative | <input type="checkbox"/> tries to hurt others | <input type="checkbox"/> respectful |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> talkative | <input type="checkbox"/> athletic |
| <input type="checkbox"/> sexually provocative | <input type="checkbox"/> sense of humor | |

8. Please describe the interventions that work best with this child:

9. Please describe this child's family situation and history. Include any information regarding custody, past physical or sexual abuse, history of substance abuse, and other information that will be helpful to staff working with this child.

Professional Referral

10. Is there any other information about this child that might be helpful for staff members to know?

11. Does the child's behavior escalate to the point of needing physical restraint? If yes, how often does this occur?
Please list any specific triggers for these incidents.

12. List three things that you hope this child will gain from a day camp experience?

- A. _____
- B. _____
- C. _____

Signature _____	Date _____
Address _____	
Phone _____	
Summer Address _____	
Summer Phone _____	



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Authorization and Information Release Forms

Child's Name _____ / /
 BIRTHDATE SEX
 Parent/Guardian _____ Phone (day): _____
 Relationship to Child: _____ 2nd Phone/Page/Cell: _____

Parent/Guardian Authorization

1. Parent/Guardian Permission. I have read the Daybreak Day Camp Information Guide, and I agree to camp procedures, policies, and behavior management techniques.

 (Parent/guardian signature) (date)

2. Photo Release. Cambridge Camping Association may use photographs, slides or video tapes showing normal camp activities for promotional and fund-raising purposes. Please sign or initial below if you give permission for the following use of your child's photograph: Please contact the office if you have any questions about viewing audience or how it affects fundraising.

Camp Movie _____ Yearbook _____
 (Parent/guardian signature) (Parent/guardian signature)

Print Materials _____ Website _____
 (Parent/guardian signature) (Parent/guardian signature)

3. Statement of Confidentiality. I understand that Cambridge Camping may contact my child's school and/or other professionals I have identified to best understand and meet the needs of my child. Cambridge Camping Association and Daybreak Day Camp will otherwise protect the confidentiality of my child and his/her family.

4. Release Authorization. I hereby authorize Daybreak Day Camp to release my child to the following persons (**other than parent/guardian**):

Name _____ Telephone number () --
 Name _____ Telephone number () --

5. Transportation Information. Parents and guardians are responsible for getting their children to the bus stop in the morning and picking them up in the afternoon. We will contact you with appropriate pick-up and drop-off times.

Does your child need transportation to and from camp? Yes No

Closest school _____ Specific bus route and designated stops will be determined based on camp enrollment.

Does your child have permission to walk home from the bus stop alone? Yes No

Does your child have permission to walk home from camp alone? Yes No

If your child does not have permission to walk home alone, an adult must meet the child each day at the bus. If no one arrives to meet the child by the appointed time, the child will be brought back to the camp site. It is then the guardian's responsibility to transport the child home.

Names of adults authorized to pick up your child: _____

6. Any changes in Release Authorization (See #4) or authorization to pick up your child (see #5) must be made in writing to the Cambridge Camping Office or to the Camp Director. No changes can be made without written authorization.

Parent/Guardian signature: _____ **Date:** _____

Information Release Agreement

I hereby authorize the following individual/agency to release information contained in the above client's record to the Camp Director of Daybreak Day Camp.

1. Name of Counselor/Social Worker/Teacher/Therapist: _____
Agency: _____ Phone: _____
Address: _____
2. Name of Counselor/Social Worker/Teacher/Therapist: _____
Agency: _____ Phone: _____
Address: _____
3. Name of Counselor/Social Worker/Teacher/Therapist: _____
Agency: _____ Phone: _____
Address: _____

I further give permission for the Camp Director of Daybreak Day Camp to provide to the above agency information by phone, in person or in writing regarding the above client. I understand that this information is not to be re-released to any person or agency without my express consent, except as provided by law. I understand that I may revoke this consent to release of information at any time.

Length of authorization is one year from date of Authorization Signature.

Specific information to be released:

- Phone Contact
- Diagnostic Evaluation
- Treatment Summaries
- Psychological Testing
- Neurological, Medical and Laboratory Reports
- Other (specify) _____

_____ Authorization Signature (Must be signed by Parent/Guardian if the client is under 18 years of age.)	_____/_____/_____ Date
_____ Printed Name of Signer	_____ Relationship to Client
_____ Camp Director Signature	_____/_____/_____ Date

Please send completed reports to:

Daybreak Day Camp
Cambridge Camping
99 Bishop Allen Drive
Cambridge, MA 02139



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Tuition Rates and CDBG Form

Daybreak Daycamp has a sliding scale rate from \$155 to \$550 for its 5 week session. To determine the rate your family will pay for camp, please complete the table below. If an agency or organization will contribute, please indicate so below.

Child Name _____ / /
 AGE BIRTHDATE SEX

Please include documents verifying your income.

Copy and send to us:

- Your most recent Income Tax Form,
- or your W-2 Form,
- or copies of 3 paycheck stubs.

Do any agencies or organizations help your child? Yes No

If yes, name of agency and worker _____

Contact phone number _____

Will this agency pay for camp? Yes No

Cost of Camp

Camp tuition is determined on a sliding scale. See below for your rate.

1. **How many people are in your household?** _____
 Include all adults (working or nonworking) and children that are dependent on your household income.
2. **What is your estimated household income?** _____
 Include income for all working adults in the household, federal aid, child support or alimony payments.

Multi-child discount. \$3 discount for each additional child enrolled in camp.

# Household	Income Range for Your Household					
2	\$0 – \$18,800	\$18,801 – \$26,300	\$26,301 – \$33,900	\$33,901– \$42,000	\$42,001– \$50,000	>\$50,001
3	\$0 – \$23,300	\$23,301 – \$30,800	\$30,801 – \$39,000	\$39,001– \$49,000	\$49,001– \$58,000	>\$58,001
4	\$0 – \$27,800	\$27,801 – \$35,200	\$35,201 – \$44,600	\$44,601– \$55,000	\$55,001– \$65,000	>\$65,001
5	\$0 – \$32,400	\$32,401 – \$45,600	\$45,601– \$56,000	\$56,001– \$64,000	\$64,001– \$73,000	>\$73,001
Cost	\$155	\$230	\$280	\$340	\$415	\$550

Based on the above rates, how much will you pay ? _____

FY2012 CDBG CLIENT BENEFICIARY INFORMATION

Our agency receives Community Development Block Grant (CDBG) funding from the Federal Housing and Urban Development Department (HUD). They require that we obtain the following information. This information is collected for statistical reasons only and is kept in strict confidence. Please help us by filling in the information on this form. If you have any questions, our staff will be glad to help you.

(please print)

FIRST NAME: _____ **LAST NAME:** _____

STREET ADDRESS: _____ **CITY/STATE:** _____

1. Total number of members in your household: _____

2. Please check the category in which the combined gross annual income of your household falls:

# OF MEMBERS IN HOUSEHOLD	LOW INCOME	LOW/MODERATE INCOME	ABOVE MODERATE
1-member	_____ up to \$34,250	_____ \$41,100-\$45,500	_____ \$45,500+
2-members	_____ up to \$39,150	_____ \$46,980-\$52,000	_____ \$52,000+
3-members	_____ up to \$44,050	_____ \$52,860-\$58,500	_____ \$58,500+
4-members	_____ up to \$48,900	_____ \$58,680-\$65,000	_____ \$65,000+
5-members	_____ up to \$52,850	_____ \$63,420-\$70,200	_____ \$70,200+
6-members	_____ up to \$56,750	_____ \$68,100-\$75,400	_____ \$75,400+
7-members	_____ up to \$60,750	_____ \$72,780-\$80,600	_____ \$80,600+
8-members+	_____ up to \$64,550	_____ \$77,460-\$85,800	_____ \$85,800+

3. RACE/ETHNICITY – each client is required to complete both the “Ethnicity” and the “Race” boxes:

<p>ETHNICITY (please select one): _____ <i>Hispanic or Latino</i> _____ <i>Not Hispanic or Latino</i></p>

<p>RACE (please select one):</p> <p>_____ American Indian or Alaska Native _____ American Indian/Alaska Native & Black/African American _____ American Indian/Alaska Native & White _____ Asian _____ Asian/White</p>	<p>_____ Black or African American _____ Black/African American & White _____ Native Hawaiian or Other Pacific Islander _____ White _____ Other Multi-Racial (<i>not listed above</i>)</p>
--	--

4. MISCELLANEOUS:

_____ Female Head of Household
 _____ Person with disability

_____ 62 years of age or over

I certify that the information I have provided on this form is true and accurate to the best of my knowledge.

Client Signature

Date



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Parent/Guardian's Health Form

Has your child had a doctor's exam since September 1, 2010

Yes → Attach a copy of that exam now. Include immunization history.

No → Call your doctor's office to make an appointment now.

Appointment Date: _____ Time: _____

Child Name _____ / /

AGE BIRTHDATE SEX

Address _____ MA

STREET APT CITY STATE ZIP

Emergency Contacts

We will always try to contact a parent first, but we MUST have three adult contacts with different daytime phone numbers.

1. Parent/Guardian _____ Phone (day): _____

Relationship to Child: _____ 2nd Phone/Page/Cell: _____

2. Name _____ Phone (day): _____

Relationship to Child: _____ 2nd Phone/Page/Cell: _____

3. Name _____ Phone (day): _____

Relationship to Child: _____ 2nd Phone/Page/Cell: _____

This sheet must have at least 3 DIFFERENT NAMES and phone numbers.

Health Insurance Information

Child's Physician _____ Phone _____

Health Insurance Provider Name _____

Card Number _____ Phone _____

Medications

Does your child take any medications on a regular basis? **Yes** **No**

If yes, will your child need to take this medication while at camp? **Yes** **No**
 at home? **Yes** **No**
 during the school year only? **Yes** **No**

Name of medication _____

Diagnosis (Reason for taking medication) _____

**If your child will need to take medication at camp, the
 MEDICATION FORM (back of doctor's form)
 must be completed by you AND your child's doctor by June 1, 2012.**

Other Concerns

Please describe any **special** concerns you have about your child's health at camp _____

Please describe any emotional or physical **special** needs or attention your child may need at camp _____

Please notify camp if your child is exposed to any communicable diseases during the 3 weeks prior to attending camp.

Authorization

This must be signed before your child may attend camp.

1. This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by me and the examining physician.
2. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.
3. I give permission for my child to receive non-prescription medications for the treatment of minor illnesses, such as headache, upset stomach, and sunburn and for the prevention of sunburn (sun screen) and bug bites (insect repellent).

Parent/Guardian signature: _____ **Date:** _____

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Cambridge, MA 02139



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***This form can be substituted by a signed print-out from your child's doctor dated after Sept. 2010**

Doctor Form

CHILD'S FIRST NAME _____ LAST NAME _____ GENDER _____ BIRTHDATE _____ / /

Note to Parents: A print-out including physical exam, immunization history, and doctor's signature may be substituted.

If your child will need to take medication at camp, see the back of this form

General Examination: Date of Exam _____ Physical exam must be no earlier than September 1, 2010

Height: _____ Eyes: _____ Glasses: _____ Ears: _____ Nose: _____
 Throat: _____ Teeth: _____ Heart: _____ Lungs: _____ Abdomen: _____
 Hernia: _____ Extremities: _____ Skin: _____ Weight: _____ Hgb. Test: _____
 Urinalysis: _____ Blood Pressure: _____ Posture (spine): _____ Other: _____

Immunizations: Give complete history, month and year

	TYPE	DATE	TYPE	DATE
Measles/Mumps/Rubella (MMR)	Measles	1.	Hepatitis B (required if born after 1/1/92)	1.
	Measles	2.		2.
	Mumps	(3.)		3.
	Rubella	(4.)	N/A	
Polio	OPV/IPV	1.	Diphtheria/Pertussis/Tetanus (4 doses DTaP/DTP or 3 doses Td)	DTaP/DTP 1.
	OPV/IPV	2.		DTaP/DTP 2.
	OPV/IPV	3.		DTaP/DTP 3.
	OPV/IPV	(4.)		DTaP/DTP 4.
Varicella (chickenpox)		1.	Tetanus Booster (Td)	N/A

Health History: Give date of illness and check box for each condition child has had

General Health: Ear Infections _____ Rheumatic Fever _____ Heart Defect _____
 Diabetes _____ Convulsions _____ Bleeding Disorder _____
 Diseases: Chicken Pox _____ German Measles _____ Asthma _____
 Measles _____ Mumps _____
 Allergies: Hay Fever _____ Insect Stings _____ Foods (list) _____
 Poison Ivy _____ Penicillin _____ Other Drugs (list) _____

Has your child ever been stung by a bee? _____

Chronic or Recurring Illness, Other Diseases: _____

Activities to be encouraged: _____

Activities to be restricted: _____

Recommendations and restrictions while at day camp (please describe for each activity)

Medication _____ Diet _____

Swimming/Diving _____ Strenuous Activity _____

I have examined this person, reviewed the health history and in my opinion feel this person is physically able to engage in day camp activities except as noted above.

Physician's Signature _____ **Date examined** _____

Physician Name (print) _____ Phone _____

Address _____

Medication Form

Complete this sheet with your doctor if your child will take medication at camp.

Please list each medication (including over-the-counter ones) that your child needs to receive at camp.

This form must be signed by the parent or guardian and the child's health care provider.

→Name of medication _____

Diagnosis (Why is your child taking this medicine?) _____

Dosage _____ How often _____

Possible side effects and action required _____

→Name of medication _____

Diagnosis _____

Dosage _____ How often _____

Possible side effects and action required _____

→Name of medication _____

Diagnosis _____

Dosage _____ How often _____

Possible side effects and action required _____

Inhalers and Epi-pens

Should your child have immediate access to his/her epipen inhaler all times at camp? Yes No

Does your physician recommend your child carry it on him/her at all times? Yes No

All medications taken at camp must be in their original bottles.

I hereby give permission to Daybreak Daycamp staff to administer to my child the above medications.

Parent/Guardian's signature: _____ Date: _____

Physician's signature: _____ Date: _____

Print physician's name: _____ Phone _____

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