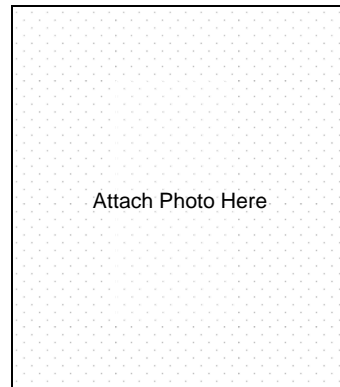




CAMP GONNAWANNAGOAGIN REGISTRATION FORM

Please return this application to FACT:

P.O. Box 1195
Virginia Beach, VA 23451
Phone: (757)422-2040
Fax: (757)306-7055
Email: pam4fact@peoplepc.com



CIRCLE ALL THE DATES YOU ARE INTERESTED IN HAVING YOUR CHILD ATTEND:

Campers may participate for up to three weeks. Do not indicate preference (i.e. 1st choice, 2nd choice)

July 7-11	Monday-Friday	9:00 am - 3:00 pm
July 14-18	Monday-Friday	9:00 am - 3:00 pm
July 21-25	Monday-Friday	9:00 am - 3:00 pm
July 28- August 1	Monday-Friday	9:00 am - 3:00 pm
August 4-8	Monday-Friday	9:00 am - 3:00 pm
August 11-15	Monday-Friday	9:00 am - 3:00 pm

For Office Use Only:

Date Received: _____

Conf. Sent: _____

Tuition Received _____

CHILD'S T-SHIRT SIZE: S M L ADULT T-SHIRT SIZE: S M L XL

*If you do not select a size, one will be selected for you

Cost of camp is \$275 for the week

Pay by Check (Please make checks payable to **F.A.C.T**)

OR

Pay with Visa/Master Card

Name on Card _____ Card Number _____ Exp. Date _____

CAMPER / STUDENT INFORMATION

Camper's Name (Last) _____ (First) _____

Nickname _____

Date of Birth _____ Age _____ Sex _____ Approximate Height _____ Weight _____

Present School _____ Teacher's Name _____

Type Classroom (Aut, Cross Cat., EBD, etc.) _____

Home Address _____

Home Phone _____ City _____ State _____ Zip _____

PARENT / GUARDIAN INFORMATION

Primary Contact _____ Relationship _____

Email Address _____ Cell Phone _____ Business Phone _____

Secondary Contact _____ Relationship _____

Email Address _____ Cell Phone _____ Business Phone _____

TRANSPORTATION INFORMATION

Person(s) Authorized to Pick Up Child _____

Person(s) NOT Authorized to Pick Up Child* _____

*Appropriate legal documents must accompany this form if someone is not authorized to pick up the child.

MEDICAL INFORMATION

Your child's doctor _____

Doctor's phone number _____

Your child's primary diagnosis _____

Allergies _____

Medication taken at home: _____

IMPORTANT: FACT employees cannot administer ANY medications.

Date of last tetanus: _____

Injury or illness that might limit your child's physical activity or participation in the camp programs.

Please provide any other information Camp Gonnawannagoagin should have in order to safeguard the health of your child.

Are you comfortable taking your child into the community?

Please list activities that your child finds aversive: (Ex. loud places, crowded places, beach, movies, etc.)

Please list activities that your child particularly enjoys:

TEACHER/PARENT COMMUNICATION ASSESSMENT OF _____ :

Name of Child

Can your child communicate his/her wants and needs?

Yes No Speech Describe: _____

Yes No Gestures Describe: _____

Does your child use any communication systems?

Yes No Describe: _____

Does your child ask for help?

Yes No Describe: _____

Does your child follow simple directions? Does he/she require prompts or gestures?

Yes No Examples: _____

Is your child prone to emotional upsets/tantrums? How can we assist your child if they become upset?

Yes No Comments: _____

Does your child:	Never	Rarely	Sometimes	Frequently
Head Butt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinch/Scratch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Explitives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throw Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refuse to Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child transition from one activity to another?

Yes No Comments: _____

Does your child pay attention to warnings of danger? Please explain.

Yes No Examples: _____

Does your child show appropriate fear of unsafe situations? Please explain.

Yes No Examples: _____

Does your child require assistance with toileting?

Yes No Describe: _____