indian trails camp

# 2017 JACK'S PLACE WEEK CAMP APPLICATION

*Jack's Place for Autism Foundation at Indian Trails Camp*

## CONTACT INFORMATION

CAMPER'S NAME: _____
Last First

T-SHIRT SIZE: ☐ YOUTH (size) _____ OR ☐ ADULT (size) _____

ADDRESS: _____
Street City State Zip

PHONE: (_____)_____ GENDER: ☐ Male ☐ Female BIRTH DATE: _____/_____/_____

AGE (as of camp session): _____ COUNTY: _____

ETHNIC BACKGROUND (optional): _____ HAS CAMPER ATTENDED ITC BEFORE: ☐ Yes ☐ No

**EMAIL ADDRESS:** _____

*No person shall be excluded from programs because of race, religion, sexual preference, disability or national origin.*

## PRIMARY CONTACT

_____ ☐ Parent ☐ Guardian ☐ Camper ☐ Other ☐ Authorized Pick Up

ADDRESS (if different): _____
Street City State Zip

PRIMARY PHONE: _____ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

ALTERNATE PHONE: _____ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

**EMAIL ADDRESS:** _____

## SECONDARY CONTACT

_____ ☐ Parent ☐ Guardian ☐ Camper ☐ Other ☐ Authorized Pick Up

ADDRESS (if different): _____
Street City State Zip

PRIMARY PHONE: _____ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

ALTERNATE PHONE: _____ ☐ Home ☐ Work ☐ Cell ☐ Accept Text Messages

**EMAIL ADDRESS:** _____

## ALTERNATIVE CONTACT #1:

_____ ☐ Authorized Pick Up

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

## ALTERNATIVE CONTACT #2:

_____ ☐ Authorized Pick Up

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

**IS THERE ANYONE WHO IS NOT ALLOWED TO PICK UP THIS INDIVIDUAL?** _____

## JACK'S PLACE WEEK... *A traditional, overnight summer camp for campers ages 7 and up on the Autism Spectrum*

Please send your application and financial form with your deposit as soon as possible to reserve your spot. If an agency or insurance company pays in full for your time at Camp you do not need to send a deposit.

NOTE: Please send all forms as soon as they are completed. Final acceptance/confirmation notices will be sent once all completed paperwork is received. We would advise you to mail us the completed application and financial form even if you do not have the physical form completed so that your spot is reserved. Then mail in the physical form upon completion but no later than 2 weeks prior to camp session.

## SESSIONS

| SESSION OPTIONS | DATES | # OF NIGHTS |
|---|---|---|
| ☐ Half Session #1 | August 6 - August 9 | 3 Nights |
| ☐ Half Session #2 | August 9 - August 12 | 3 Nights |
| **OR** | | |
| ☐ Full Session | August 6 - 12 | 6 Nights |

Mail applications to:

Indian Trails Camp
O-1859 Lake Michigan Dr NW
Grand Rapids, MI 49534

Or Fax to: 1 (616) 677-2955

Email: info@ikuslife.org

All registration/drop off times are between 4:00 p.m. and 5:00 p.m., and pickup times are between 10:00 a.m. and 11:00 a.m.

## FINANCIAL FORM

Camper Name: _____ Age: _____ County: _____

**1. Review the attached Level Determination Form and indicate below the level of care required for the camper.**

| | | |
|---|---|---|
| __LEVEL 1 Minimal Dependence | $381 (3-nights) | $762 (6-nights) |
| __LEVEL 2 Moderate Dependence | $558 (3-nights) | $1,116 (6-nights) |
| __LEVEL 3 Complete Dependence/Supervision 1:1 | $768 (3-nights) | $1,536 (6-nights) |

*If at any time after receipt of this form and camper application, the Camp Director and/or Health Director find the camper to require a different level of care than indicated, Indian Trails Camp reserves the right to change the level and fee accordingly. The camper and/or family will be notified if such change occurs.*

**2. Based on the above Level Determination, complete the following calculations.**

6 night session fee: $_____

OR 3 night session fee: $_____

**Total Fees Due:** $_____

**Less payments sent with application:**

Deposit (if applicable*): - $_____

Other (additional amount towards balance, if desired): - $_____

**Remaining Balance Due:** **$**_____

* If a third party is being billed for the entire amount, a deposit is not required.

**3. Complete A, B, C and/or D to indicate method & source(s) of payment. Note that the remaining balance per #2 above is due 1 week before the session start date for parent/guardian/self payments. If a scholarship is requested and granted, that amount will be deducted from the indicated payment option.**

A. Check: Amount paid with application _____ Check # _____

B. Credit Card (Visa, Mastercard & Discover accepted):

Amount to charge now $_____ Amount to charge 1 week prior to session start date $_____

Card # _____ - _____ - _____ - _____ Exp Date _____/_____

Name as it appears on card _____ Ph # (_____)_____

Card billing address _____ Zip Code _____

C. Third Party Payment:
If you expect a third party (such as Community Mental Health, Network 180 or insurance company) to pay for all or a portion of the camp fees, please complete this form. We highly recommend that you confirm the amount to be paid with the third party. If the third party pays less than the amount indicated, you will be responsible for the difference.

Name of organization to be billed:_____

Contact person (eg. supports coordinator, case manager): _____

Ph # (_____)_____ Fax # (_____)_____

Email address if invoice may be emailed: _____

Amount to be paid: _____

Send bill: _____before (or) _____after session.

D. Scholarship

___ I have a financial need and will request a scholarship

NOTE: Scholarship applications are due April 22. You will be notified by April 30. Applications will be accepted after April 22, but we cannot guarantee the availability of funding. Those applications will be processed if and when funding becomes available. Campers are eligible for a maximum of a 1 week scholarship.

**4. For information about refunds and cancellations, please see attachment.**

## CAMPER INFORMATION

**CAMPER NAME:** _____ **BIRTHDATE:** _____ ☐ **Male** ☐ **Female**

**SESSION(S):** _____ **NICKNAME, IF ANY:** _____

*Check all applicable:*
**DISABILITY:**

- ☐ Cerebral Palsy
- ☐ Muscular Distrophy
- ☐ Spina Bifida
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy
- ☐ Arthrogryposis
- ☐ Osteogenesis Imperf.
- ☐ Visual Impairment
- ☐ Autism/ASD
- ☐ Down's Syndrome
- ☐ Congenital Anomolies/Birth Defects:

  *Explain in detail* _____

  _____

  _____

  _____
- ☐ CHI (Closed Head Injury)
- ☐ Mental Impairment
  - ☐ Mild (Cognitive Impairment)
  - ☐ Moderate
  - ☐ Severe
- ☐ Other *(please explain)* _____

  _____

  _____

**CABIN MATE REQUESTS:**
*Please list any requests you have for cabin mates. We will do our best to accommodate your request.*

1: _____

2: _____

**CAMPER IDENTIFICATION:**

☐ Please enclose or attach a recent head shot photo of camper with application (to be used for nursing identification).

**COMMUNICATION:**

- ☐ No communication difficulties
- ☐ Verbalizes, may be difficult to understand
- ☐ Non-verbal, yes/no responses only
- ☐ Uses a communication device

*Explain communication board or system*

_____

_____

_____

*Additional helpful information*

_____

_____

_____

**GENERAL HEALTH INFORMATION:**
Does camper have regular seizures?
☐ Yes ☐ No

If yes, please indicate frequency, length, severity, triggers, & common signs/ conditions of seizure _____

_____

_____

_____

Does the camper have allergies?
☐ Yes ☐ No

If yes, please explain agent and reaction in detail _____

_____

_____

Is the camper allergic to service dogs? ☐ Yes ☐ No

Will camper bring an Epi Pen?
☐ Yes ☐ No

**SPECIAL EQUIPMENT THAT CAMPER WILL BE BRINGING TO CAMP:**

**AMBULATION:**

- ☐ Crutches ☐ Walker
- ☐ Wheelchair ☐ Elec. Wheelchair
- ☐ Scooter ☐ Other

**EATING:**

- ☐ Special Cup ☐ Special Dish
- ☐ Plate Guard ☐ Special Utensils
- ☐ Other

**OTHER:**

- ☐ Hoyer Lift ☐ Toilet Commode
- ☐ Communication Board
- ☐ Helmet
- ☐ Pace Maker ☐ Other

**BRACING:**

- ☐ AFO ☐ Hand Splint
- ☐ Other

Please indicate camper's dietary needs, if any:

☐ Chopped Food ☐ Pureed Food ☐ No Dietary Restrictions
☐ Food Allergies/Intolerances ☐ Diabetic

List any food allergies/intolerances or describe diabetic needs (eg. insulin shots, etc.)

_____

_____

## ACTIVITIES OF DAILY LIVING

### EATING:

☐ Independent

☐ Needs only food cut and plate set

☐ Must be fed

### AMBULATION:

☐ Walks ☐ Independent

☐ Needs assistance *(describe)*: _____

_____

_____

☐ Depends on mobility device *(describe)*: _____

_____

_____

### DRESSING & UNDRESSING:

☐ Independent

☐ Need assistance with fine motor skills

☐ Total assistance

### PERSONAL CARE INFORMATION:

*Check any which camper will need assistance with*

☐ Showering

☐ Shaving

☐ Teeth-brushing

☐ Personal care: menstrual cycle

### TOILETING:

☐ Wears briefs

☐ Independent

☐ Needs assistance *(describe)*: _____

_____

_____

☐ Special bowel treatment/program (describe): _____

_____

☐ How often does camper have bowel movements? ___

_____

### Sleeping Habits:

☐ Sleeps through the night ☐ Requires bedrails

☐ Wanders at night

☐ Needs care during the night (turning or changing)

### TRANSFERS:

Approx. weight: _____

☐ Independent

☐ Can bear weight for pivoting

☐ Must be lifted

Precautions that should be taken for transfers, if any:

_____

### BEHAVIOR NEEDS*:

Does camper have any behavioral needs?

☐ Yes ☐ No

If yes, please describe:

| *Description* | *Frequency* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

How might we best accommodate these behaviors?

_____

_____

_____

### ADJUSTMENT TO CAMP:

Any fears? If so, please explain: _____

_____

_____

_____

### OTHER:

Anything else you would like us to know? _____

_____

_____

*For information on our behavior policy, please see attachment

## CAMPER BEHAVIOR & CAMPER ELIGIBILITY FOR SUMMER CAMP & RESPITE PROGRAMS POLICY

Indian Trails Camp summer camp and respite programs are designed for children and adults with disabilities ages 5 & up. Programming gives campers the opportunity to engage in recreational, social and traditional camp experiences.

In order to maintain a quality program, sessions are designed to accommodate specific needs of campers through staffing ratios, programming, and activity goals.

Registration in sessions will be based on camper needs and interests as identified by the camper, camper's parent/guardian or other support team members (e.g. AFC staff, case managers, etc.) in the camp application.
Indian Trails Camp will conduct continual assessment of camper needs and behaviors through administration's daily observations and cabin staff camper appraisals. If the Summer Camp & Respite Coordinator (or Executive Director) feels that a camper would be better suited for a different session or would require additional support, contact with the camper and/or their guardian will occur, as well as documentation for the camper's file.

Indian Trails Camp is a recreational and social program and not deemed a treatment facility. Campers who require physical management are not suitable for Indian Trails Camp summer camp and/or respite programs due to the safety of the camper, other campers and ITC staff.

Before a camper is considered not eligible for any camp program, a discussion will occur between the camper and/or their guardian, the Summer Camp & Respite Coordinator and the Executive Director.

Under NO circumstances will a camper be deprived of food or sleep, or be isolated without staff supervision, observation, and interaction, or be subjected to hazing, ridicule, threat, corporal punishment, excessive physical exercise, or excessive restraint.

All Indian Trails Camp staff who are responsible for the supervision and care of campers will be trained in but is not limited to the following;

1) Recipient Rights
2) Positive Behavior Interventions and Techniques
3) Working with People with Disabilities
4) OT (including feeing, transfers, changing, direct care needs)
5) CPR & First Aid

All recurrent behavior issues with campers will be reported to and handled by administration in the following order.

1) Head Counselor
2) Summer Camp & Respite Coordinator
3) Executive Director

All camper applications are reviewed by the Summer Camp & Respite Coordinator, Executive Director and Nursing team to ensure that Indian Trails Camp is able to meet the needs and wants of campers. Indian Trails Camp holds the right to refuse service at any time which includes following confirmation of registration, and check-in. Camper behaviors or incidents that may lead to this include, but is not limited to: Severe self-injurious behaviors, significant self-stimulating behaviors, intentional and unintentional property destruction.

If the Summer Camp & Respite Coordinator observes the guardian or caregiver having to physically redirect a camper, if the camper attempts to flee or elope, or becomes physically aggressive during check-in, we will discuss with the camper or guardian the incident(s) and may not have the camper continue through registration or stay for the session.

At any time following check-in, if a camper is having unprovoked bouts of aggression, and is not responding to redirection or de-escalation, the guardian will be contacted and is responsible to arrange transportation for immediate pick up of the camper.

By signing below, I have reviewed and understand this Policy.

Reviewer Signature: _____ Date: _____

## LEVEL DETERMINATION

### LEVEL 1 (1:3)

Campers are provided one direct care counselor per three Level 1 campers.

Level 1 is for campers who are able to perform most of their ADL's (Activities of Daily Living) independently.

Campers in this level take between 0-4 medications per day and do not have any current ongoing medical concerns.

Camper is independent with eating, or requires some verbal prompts and/or minimal physical assistance (e.g. cutting up food).

Camper is independent with hygiene needs, or may require some verbal prompts to ensure completion or thoroughness.

Camper is independent with toileting, or requires minimal verbal prompts.

Camper is independent with practicing coping skills and staying focused on task at hand, or requires minimal verbal prompts or redirection.

### LEVEL 2 (1:2)

Campers at this level are served with one direct care counselor per two campers.

Level 2 campers require some physical assistance but are independent in other areas of care.

Camper in Level 2 may not exceed 8 medications per day, and have minimal medical concerns.

Camper may require minimal physical assistance with accessing food at meals, and/or requires specialized diet/nutrition (e.g. pureed food).

Camper may require minimal physical assistance with hygiene needs to ensure completion or thoroughness.

Camper may require minimal physical assistance (e.g. wiping) with toileting.

Camper may require verbal prompts or redirection with practicing coping skills and staying focused on the task at hand.

Camper may be dependent on a mobility device (e.g. walker, cane, etc.) but is able to use this primarily independently.

### LEVEL 3 (1:1)

Level 3 is reserved for campers who need on-to-one assistance the majority of the time due to medical or behavioral situations.

Medications may exceed 8 per day.

Campers who require medical treatments such as feeding tubes and severe seizure monitoring are automatically Level 3.

Camper may require full assistance with accessing food at meals.

Camper may require full assistance with most or all hygiene needs.

Camper may require full assistance with toileting, including transferring, diapering, and wiping.

Camper may require verbal prompts and redirection with practicing coping skills and staying focused on task at hand most to all of the time.

Camper may be dependent on a mobility device (e.g. manual/ electric wheelchair, scooter, etc.) at all times, and may be independent with using it or need assistance.

Camper may be a flight risk.

## INSURANCE FORM

**CAMPER NAME:** _____

***IMPORTANT:** Indian Trails Camp, Inc. does not carry medical/accident insurance for campers. It is the responsibility of the camper/guardian to obtain adequate insurance coverage for any medical needs, including accidents.

**I UNDERSTAND THE ABOVE:** _____

*Signature of parent/guardian or adult camper*

**IS THE CAMPER COVERED BY MEDICAL INSURANCE?:** ☐ Yes ☐ No

If yes, please list the camper's health insurance carrier (examples: Blue Cross, Medicare, PPOM, etc.)

_____

_____

**POLICY NUMBER:** _____

**CONTRACT NUMBER:** _____

**CARD HOLDER'S NAME:** _____

**ADDITIONAL INFORMATION:** _____

_____

## CAMPER PHYSICAL FORM

*All overnight summer campers must have a physical form on file that is dated within 12 months* of their camp session date. It must be signed by a physician and submitted at least 2 weeks prior to the session start date. It does not need to be mailed with the application, but must be received 2 weeks prior to the session start date. or the camper will be removed from the session.*

**CAMPER NAME:** _____ **DOB:** _____ **SEX:** _____

1. Applicant must be diagnosed with a physical, developmental or cognitive disability or mental illness.
2. Applicant must be capable of social interaction and participation in camp activities.
3. Applicant must be able to communicate needs through at least a yes or no response (e.g. eye blinks, headshake, use of communication board, etc.).

**PRIMARY DIAGNOSIS/DISABILITY:** _____

**SECONDARY DIAGNOSIS:** _____

**MEDICAL HISTORY:**

☐ Asthma/Respiratory problems

☐ Diabetes Type: _____

☐ Heart Defect ☐ Apnea

☐ Kidney Disorder ☐ Other

☐ Seizures

☐ Down Syndrome: Atlanto Axial Instability? ☐ Yes ☐ No

Immunizations (check all that have been issued and provide immunization dates):

☐ Diphtheria _____/_____/_____

☐ Pertussis _____/_____/_____

☐ Measles _____/_____/_____

☐ Polio _____/_____/_____

☐ Small Pox _____/_____/_____

☐ Rubella _____/_____/_____

Date of last Tetanus shot (must be within 10 years):

_____/_____/_____

Does the camper frequently suffer from any of the following? (check all applicable)

☐ Headaches ☐ Sore Throat ☐ Ear Infections

Does the camper have known communicable diseases?

☐ Measles ☐ HIV Positive

☐ Chicken Pox

☐ Hepatitis ☐ A ☐ B ☐ C

☐ Other: _____

Allergies and Reaction: _____

_____

_____

Epi Pen? ☐ Yes ☐ No

Does the individual have a diabetes diagnosis? ☐ Yes ☐ No

If yes, explain needs: _____

_____

**CURRENT HEALTH:** Height: _____ Weight: _____ BP: _____ HR: _____ RR: _____ Temp: _____ Pulse Ox: _____

**OVERALL HEALTH CONDITION:** _____

Other information for health care staff, including treatments to be continued at camp, activity restrictions, medically prescribed meal plan, or dietary restriction while at camp:

**I have reviewed the camper's health history and discussed the camp program with the camper and/or parent/guardian. It is my opinion that the applicant is physically and emotionally fit to participate in the session at Indian Trails Camp (except as noted above).**

*Physician's Signature* *Date* *Physician's Office Name & Phone #*

**For example, if the physical is dated 8/1/16 and the camper is attending a June 2017 session, we would not need an updated form.*

## MEDICATION RECORD

**Please list ALL medications. The back of this sheet may be used if needed.**

**NOTE:** Camp medications are distributed at 9am, 12 noon, 2-4pm, 5pm, and 9pm. Any deviations must be indicated by a physician. Only medications and dosages listed on this form will be approved on camp registration day. Any medications not listed on this form will not be administrated at camp without prior written approval of the physician. This includes ALL over the counter non-prescription and prescription medications. Medications must be brought in their original bottles. If you choose to bring them set up in a med container, pill bottles must still be brought to verify prescription.

| Name of Medication | Dosage | Prescription, as listed on bottle** | Time(s) given |
|---|---|---|---|
| *e.g. Depakote* | *250mg* | *3 tabs by mouth twice daily* | *9am and 9pm* |
| | | | |
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**Please be sure to obtain written approval for any deviations of prescriptions written on bottle prior to camp registration.

## SICK/INJURED CAMPER POLICY

All campers receive a preliminary screening for contagious and/or noncontagious illnesses and diseases occurs at check-in. If there are signs of pink eye, anything worse than a common cold, gastrointestinal bugs or any other illness or diseases within the past two weeks of coming to camp, we reserve the right to send the camper home and reschedule for another session if available.

Nursing personnel will bring any non-critical health issue requiring off-site medical treatment to the attention of the Summer Camp & Respite Coordinator.

Together, the Summer Camp & Respite Coordinator and guardian (or AFC home if applicable), will decide as to whether treatment should be pursued at an off-site medical site or not.

Any illness that requires the camper to be excluded from participation in the camp program for more than twenty-four (24) hours will be cause for guardian to be contacted.

If the camper has a fever higher than 100.4 accompanied by vomiting and or diarrhea, which lasts more than 12 hours or does not show improvement, the camper will be sent home.

If a camper refuses to leave the camp facility or the guardian (or AFC home if applicable) refuses to pick up the camper, a call will be made to the licensing representative and a mandatory report will be filed.

By signing below, I have reviewed and understand this Policy.

Reviewer Signature: _____ Date: _____

## NON-CRITICAL EMERGENCY & EMERGENCY TRANSPORTATION POLICY & PROCEDURE

Indian Trails Camp will have available, at all times, a vehicle which is designated for non-critical emergency transportation. If the vehicle is unavailable, the Summer Camp & Respite Coordinator will designate another appropriate vehicle to serve such a purpose.

The non-critical emergency vehicle will be in good working order and shall have a sufficient supply of fuel to reach the closest twenty four (24) hour emergency facility and back.

Indian Trails Camp staff that are transporting a camper may have one additional staff to accompany them depending on the needs and injury of the camper. Transporting staff must be on the current Indian Trails Camp auto insurance and have a clean and clear driving record.

For emergency transportation, the Summer Camp & Respite Coordinator or nursing staff will call 9-1-1 for an ambulance. An Indian Trails Camp staff will either ride along with the camper in the emergency vehicle or meet them at the hospital or treatment site.

Once the camper receives treatment, the guardian or other support team member (e.g. AFC staff, case manager etc.) is responsible for the camper. Or if the camper is admitted in the hospital or treatment site, Indian Trails Camp staff are no longer responsible for the camper. It is the guardian's responsibility to make arrangements for someone to accompany and be present immediately following admittance.

Indian Trails Camp does not charge for non-critical emergency transportation. If emergency transportation is used, Indian Trails Camp is not responsible for any ambulance fees or any other outside transportation fees.

By signing below, I have reviewed and understand this Policy & Procedure.

Reviewer Signature: _____ Date: _____

## HEALTH CARE AUTHORIZATION

**Camper's Name:** _____

The medical facilities listed below are utilized by ITC. Please check the facility that is preferred in the event of an emergency or need for additional medical treatment.

**FACILITY:**

☐ Mercy Health (approximately 15 miles east of ITC in downtown Grand Rapids)

☐ Spectrum Health (approximately 10 miles east of ITC in downtown Grand Rapids)

☐ Metro Health (approximately 15 miles southeast of ITC near M-6 and Byron Center Ave)

☐ Other hospital _____

☐ Spectrum Health Occupational Services (non emergencies)

☐ No preference

I hereby give permission to Indian Trails Camp, which is licensed by the State of Michigan, to provide routine, nonsurgical medical care; administer medications; order x-rays and/or routine tests; release any records necessary for insurance purposes; provide or arrange necessary related transportation; and to secure emergency medical and surgical treatment. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Indian Trails Camp management to secure and administer treatment, including hospitalization for the camper listed above, while attending Indian Trails Camp.

**NOTE 1:** In accordance with MCLA Act 116 of the Public Acts of 1973, as amended, and the rules for licensing camps, this authorization must be signed by the parent or guardian of a minor camper, unless there is religious objection.

**NOTE 2:** In accordance with MCLA Act 218 of the Public Acts of 1979, as amended, and the rules for licensing camps, this authorization must be signed by the authorized person of an adult camper, unless there is religious objection.

_____ _____

*Signature* *Date*

Relationship to camper: ☐ Self ☐ Guardian/Parent

## GENERAL LIABILITY RELEASE

I understand that Indian Trails Camp (ITC) assumes no responsibility for injuries, which I or my child may sustain as a result of my or my child's physical condition, or resulting from my or my child's participation in any activities, programs, exercise, or the use of any facility, equipment, or other activities organized or sponsored by ITC. I expressly acknowledge that I assume risk for any and all injuries and illnesses that may result. In consideration of the privilege of using ITC, I hereby voluntarily release and discharge ITC, it's agents, servants, and employees from any and all claims for injury, death, loss or damage that I or my child may suffer. I understand that ITC is NOT responsible for personal property lost or stolen while members and/or program participants are using ITC facilities or on ITC premises.

*Date* *Adult Camper or Parent/Legal Guardian*

## PHOTO RELEASE

I understand that Indian Trails Camp (ITC) loves to take pictures of guests enjoying themselves during their stay at camp, and that the photos are often used in marketing and promotional materials. ITC has my permission to use any media of me or my child at camp for purposes of promoting or describing ITC programs.

If you prefer that photos of you or your child not be used, please let us know in writing prior to the camp experience.

*Date* *Adult Camper or Parent/Legal Guardian*

## SUMMER CAMP & RESPITE PROGRAMS CANCELLATION/REFUND POLICY

**Summer & Holiday Camp**

- All refunds are subject to a $100 cancellation fee.
- Refunds will be given if cancellation of session occurs at least 7 days prior to the session start date.
- If cancellation occurs less than 7 days prior to the session start date, refunds will be given only for medical reasons or a family emergency. For medical reasons we may request a doctor's note to substantiate medical reason.
- Subsequent cancellations that are less than 7 days prior to the session start date, will result in the camper being removed from all remaining registered sessions, and placed at the bottom of the waiting list.

**Respite Weekends**

- All refunds are subject to a $50 cancellation fee.
- Refunds will be given if cancellation of session occurs at least 7 days prior to the session start date.
- If cancellation occurs less than 7 days before the session start date, refunds will be given only for medical reasons or a family emergency. For medical reasons we may request a doctor's note to substantiate medical reason.
- Subsequent cancellations that are less than 7 days prior to the session start date, will result in the camper being removed from all remaining registered sessions, and placed at the bottom of the waiting list.

**Day Camp**

- All refunds are subject to a $80 cancellation fee per day of cancellation.
- Refunds will be given if cancellation of session occurs at least 7 days prior to the session start date.
- If cancellation occurs less than 7 days before the session start date, refunds will be given only for medical reasons or a family emergency. For medical reasons we may request a doctor's note to substantiate medical reason.
- Subsequent cancellations that are less than 7 days prior to the session start date, will result in the camper being removed from all remaining registered sessions, and placed at the bottom of the waiting list.

For more information, please refer to www.ikuslife.org on:
*Sick/Injured Camper Policy*
*Camper Behavior & Camper Eligibility for Summer Camp & Respite Programs Policy*

By signing below, I have reviewed and understand this Policy.

Reviewer Signature: _____ Date: _____