



Application Form

Camp New Connections accepts applications on a rolling admissions basis. Priority for slots is based on the order of receipt of application packet as well as on the candidate's fit/match for a particular group. The goal of this application is to get an accurate picture of your child to determine if s/he would be appropriate for our program.

PLEASE
ATTACH RECENT PHOTO
OF APPLICANT
HERE

CHILD INFORMATION

First Name _____ MI _____ Last Name _____

Male / Female _____ Date of Birth: _____ Age _____ Return Camper (check one): Yes No

Primary Address _____ Apt. _____

City _____ State _____ Zip Code _____

DIAGNOSIS (Please check all that apply)

- Asperger's Syndrome PDD Autism Non-Verbal LD ADD/ADHD
- Sensory Integration Disorder Anxiety/Phobia Depression Obsessive/Compulsive Disorder
- Other (Please specify): _____
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-

PARENT/GUARDIAN INFORMATION

Parents' Marital Status Single Married Divorced Remarried Widowed

Child lives with: Mother Father Both Other (Please specify: _____)

Parent/Guardian #1

Parent/Guardian #2

Name: _____

Name: _____

Relationship to Child: _____

Relationship to Child: _____

Check if legal guardian _____

Check if legal guardian _____

Home Address: _____

Home Address: _____

Home Telephone #: _____

Home Telephone #: _____

Cell #: _____

Cell #: _____

Email Address: _____

Email Address: _____

Bus. Telephone #: _____

Bus. Telephone #: _____

Siblings or other significant family members in the home (state first name, gender, age): _____

SCHOOL INFORMATIONChild's current school _____ Location: _____
Name of School Town/City

Grade in September _____ Is your child in a special education program? Yes No

Which of the following describes your child's educational setting:

 Mainstreamed Special Education Alternative/Private School**Please provide the following information about any special services your child receives at school:**

Type of Service	Times per Week	Name of Provider
Speech/Language		
Occupational Therapy		
Social Skills Group		
Resource Room		
In-School Counseling		
Other:		

Does your child receive any additional services at school? (i.e., modified behavior plan, 1:1 teaching aide, reduced class size, etc.)

OUTSIDE SERVICE PROVIDER INFORMATION**Please provide the following information regarding CURRENT services your child is receiving:**

Type of Service	Times per Week	Name of Provider/Location	How long in treatment?
Therapy <input type="checkbox"/> Individual <input type="checkbox"/> Group			
Psychopharm/Medication Management			
Speech/Language			
Occupational Therapy/SI			
Social Skills Training			
Other:			

Child's Name: _____

MEDICAL INFORMATION

Child's Name: _____ DOB: _____ SS#: _____

Insurance Co: _____ Policy #: _____ Group #: _____

Name of person carrying insurance: _____

Child's Pediatrician: _____ Phone #: _____

Address: _____ Town: _____ State: _____ Zip: _____

Psychologist/Neurologist: _____ Phone #: _____

Address: _____ Town: _____ State: _____ Zip: _____

Does your child have any significant medical issues/concerns? Yes No

If yes, please describe: _____

Does your child have any specific dietary restrictions? Yes No

If yes, please describe: _____

Does your child have any allergies to the environment/food/medication?

Allergen(s)	Reaction	Remedy

Please list any medications your child is currently taking:

Name of Medication	Dosage/Time	Reason	Prescribing Physician

Child's Name: _____

ADDITIONAL INFORMATION

A. What special interests and strengths does your child have?

B. What is / are your child's current areas of need or challenges? _____

C. What has been done so far to try to meet the needs of your child? _____

D. Please describe any concerning behavioral difficulties that your child has, e.g. hitting, biting, self-injurious behaviors, etc. (Please be specific, withholding information regarding this matter may hinder our ability to handle any crises or challenging situations): _____

E. Please use the following space to add any other comments, pertinent information, or continuations of your answers if needed.

SWIMMING: Campers swim once per week at an indoor swimming facility. All campers are permitted in the shallow end. Those wishing to swim in the deep end must pass a swim test. Please provide information about your child's swimming ability: Beginner Intermediate Expert/Advanced

T-SHIRTS: All campers are provided with one Camp New Connections t-shirt on the first day of camp. T-shirts are to be worn on swimming days and on field trips. Please check your child's t-shirt size.

Child Size:	X-Small	Small	Medium	Large
Adult Size:	Small	Medium	Large	X-Large

How did you hear about us or by whom were you referred? _____

Child's Name: _____

Please attach with this application any neuropsychological testing, school evaluations, I.E.P.'s, or other information that will help us better understand and serve your child.

I / We hereby make an application to for my child / ward to attend Camp New Connections. I / We have filled out all of the information to the best of my / our knowledge.

Parent / Guardian Signature

Parent / Guardian Signature

Date

Please sign above and return the completed application form along with a \$25.00 non-refundable application fee payable to: McLean Hospital.

Applications can be mailed to:

Camp New Connections
McLean Hospital / East House I
115 Mill Street
Belmont, Massachusetts 02478-9106

Child's Name: _____