Please fill out the enclosed forms and check the week (s) of camp your child would like to attend. Make sure to indicate Farm Camp sessions and/or Horsemanship Camp Sessions. You are welcome to attend both camps!

Please Note: Horsemanship camps are Monday - Thursday

Check Week (s)	Week
	June 25 – June 29 (Classic Farm Camp) **Bus from Syracuse**
	July 2 – July 6 ("America Week" Farm Camp/Horsemanship Camp) (No camp July 4)
	July 9 – July 13 (Classic Farm Camp/Horsemanship Camp)
	July 16 – July 20 (Classic Farm Camp/Horsemanship Camp)
	July 23 – July 27 (Adult Camp Oswego/Horsemanship Camp)
	July 30 – August 3 (Classic Farm Camp/Horsemanship Camp)
	August 6 - August 10 (Adventure Camp/Horsemanship Camp)
	August 13 – August 17 (Classic Farm Camp) ***Bus from Oswego and Oneida County***
	August 20 – August 24 (Pirate Week) ***Bus from Syracuse and Madison County***
	August 27 – August 31 (Western Week) ***Bus from Syracuse***

Recreation Program Application: Please complete all sections

General Contact Information – PLEASE PRINT LEGIBLY AND COMPLETE IN FULL
About the Participant:

Last Name:_____First Name _____Middle_____

Address_____Apartment_____

City _____State_____ Zip_____

Phone Number _____Alternate Phone_____

Birthdate _____

Height _____Weight _____

Disability _____

T-shirt size _____ Youth _____ Adult

Who is filling out this application? _____ Parent/Guardian _____ Service Coordinator

Parent/Guardian Information:
Full Name _____

Address (if different than above)_____

City _____State _____Zip_____

Phone number _____Alternate Phone_____

E-mail _____

Emergency Contact: Who do we call if Parent/Guardian cannot be reached?
Full Name _____

Address (if different than above)_____

City _____State _____Zip_____

Phone number _____Alternate Phone_____

E-mail _____

Relationship_____

Jonathan's Law Contact and phone #: _____
Jonathan's Law *established procedures that facilities must follow to notify and inform parents and legal guardians of children and adults receiving services of incidents they are involved in.*

Service Coordinator Information (if applicable):
Full Name_____

Agency_____

Phone number _____

E-mail_____

Dates of Program: _____

Has the person participated in an ARISE at the Farm program in the past?
____ No ____ Yes Program:_____

Cancellations: *There will be no refunds for camp cancellations made less than 24 hours in advance. Notice of cancellation must be made via email to or phone call to the Camp Director; caitlin.bartman@ariseinc.org or via phone call to Cait Bartman at (518) 269-1132.*

Participant Health History/Medical Information

Name: Last_____First _____Middle_____

Allergy Information (please check all that apply) __ No Allergies __ Hay Fever __ Insect Stings/Bites __ Foods (explain below) __ Medications (explain below) __Use of Epipen __Other (explain below)

_____

_____

Health History (please check all that apply) __ Asthma/Wheezing/Shortness of Breath __ Measles __ German Measles __ Chicken Pox __ Mumps __ Headaches __ Hepatitis __ Rheumatic Fever __ Heart Murmur __ Diabetes __ Convulsions __ Fainting/Dizziness __ Seizure Disorder __ ADD/ADHD

Special dietary needs including food restrictions and/or modified diet:

_____

Answer all questions in relation to participant (Circle "yes" or "no". Explain all "yes" answers below)

Hospitalized within last 12 months?	No	Yes
Surgery within last 12 months?	No	Yes
Recent infectious disease within last 12 months?	No	Yes
Mononucleosis (mono) within last 12 months?	No	Yes
Been out of the country within last 12 months?	No	Yes
Take medication regularly?	No	Yes
Injuries within last 12 months?	No	Yes
Chronic/Recurring illness?	No	Yes
Passed out/had chest pain w/exercise?	No	Yes
Back/neck problems?	No	Yes
Use a wheelchair/other support?	No	Yes
Communication needs?	No	Yes
Bowel concerns/issues?	No	Yes
Wear glasses, contacts, or protective eyewear?	No	Yes
Wear hearing aids?	No	Yes
Do activities need to be limited for any reason?	No	Yes

Is participant under medical care for any reason? No Yes (explain "Yes" below)
Please note if assistance is needed with the following:
_____Eating ____Toileting _____Dressing _____Mobility _____ Communication

Please provide any additional information about the participant and/or their diet, health and/or pre-existing medical, physical or psychological conditions and illnesses that will help us ensure that they have a successful experience.

_____

_____

_____

_____

Please note: The Camp Medical Director will meet with you to discuss your camper's health needs and concerns prior to the start of camp.

Participant Health History/Medical/Behavioral Information

Name: Last_____First _____Middle_____

Will the participant be taking any medication during this program? Yes No

Current Medications

For all medications given at Farm Camp, including prescription and over-the-counter, a written order signed by the participant's physician/provider must be submitted at the start of camp (per Department of Health 7.2-5). Medications will not be given without written orders. All medications must be in the original/pharmacy container, with only one type of medication per container.

Please list below any medications the participant is currently taking.

Medication	Date started	Reason	When given	Dose	How is it Administered

Down Syndrome/Serious illness or Surgery

If the participant has Down Syndrome, it is necessary to have a cervical spine x-ray completed. If the participant has had a serious illness or surgery within the last year he/she must have this signed by a physician to attend programming. I consider this participant to be in good health at this time, and that he/she is physically able to participate in program activities.

Name of Licensed Physician (print)_____
Signature of Licensed Physician_____
Date:_____

Immunization History – a current record is required

In order to attend day programming at ARISE at the Farm, the parent/guardian must attach a current copy of the participant's immunization record from the doctor's office. This is necessary to comply with New York State Health Law Chapter 1 Sub-part 7-2.8c. Without the immunization record, the application is not complete.

Participant's Physician: _____
Physician's Address & Phone:_____

Behavioral Needs: (Check all that apply and add explain below): ____ One-to-One support
____ Sensory needs ____ Self-Injurious Behavior ____ PICA-like behavior ____ Might run away
_____
_____

Participant Information

Name: Last_____First _____Middle_____

Please help us to know your child/ family member better. We would greatly appreciate if you would take the time to answer the questions below. Feel free to provide any additional information that you may think is helpful as well.

The members of my family are (including pets):

Two things I want people to know about me are:

1.

2.

When I am happy, I will:

When I am unhappy, I will:

Some things I like to do are:

Some of my favorite things are:

Some things that I do well are:

Some things that others can do to help me are:

Some things that people try to do but that are not helpful are: