



March 29, 2021

Dear Parents and Caregivers,

We are so happy to say, **“The time is quickly approaching for an exciting year of Camp WANNAGOAGAIN 2021!”**

Camp will be at a NEW LOCATION this year. Camp Hoffman is at 2850 Ministerial Road, West Kingston, RI 02892 and is run by the Girl Scouts of Southeastern New England. The camp is beautiful and a good fit for our camp too.

Please provide your child’s ICD-10 diagnosis on page 2, as well as a unique **CODEWORD** on page 10. Be sure to remember this codeword and share it with persons picking up your child from Camp. Staff will ask for this codeword to verify identification before releasing your child.

Information from the demographic questionnaire will offer valuable data for grant applications, which will generate additional funding for future programs, groups and support services at The Autism Project.

Deadline information for camp registrations, placement letters and camp payment can be found on page 14. Kindly submit your completed Camp application to Abby Waite, no later than **June 11, 2021**. Camp applications can be mailed to The Autism Project, faxed or emailed directly to Abby at abigail.waite@lifespan.org. As always, please contact us with questions or concerns.

The camp tuition fee remains at \$550.00 per camper this year. We continue to offer a robust Campership Program and encourage you to apply. Information about transportation will be available shortly when we determine if we can provide it within the COVID-19 protocols.

We look forward to another successful year of Camp *WANNAGOAGAIN!*

Joanne G. Quinn
Executive Director
P: 401-785-2666
F: 401-785-2272



Camp *WANNAGOAGAIN!* Summer Camp Registration 2021

August 9-13 and August 16-20 (Registration deadline is June 11, 2021)

<input type="checkbox"/> New Camper		<input type="checkbox"/> Returning Camper		<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Camper's Name:				DOB:		Age:	
				Grade:			
T-Shirt Size Youth: <input type="checkbox"/> XS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL				Adult: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL			
Name(s) of Parent(s)/Caregiver(s):							
Address:		City:		State:		Zip:	
Home Phone:		Cell Phone:		Email:			
Party responsible for payment: <input type="checkbox"/> Parent <input type="checkbox"/> School							
If school is paying , name of school and contact person:							
School Address:		City:		State:		Zip:	
Office Phone:		Email:					
Camper Information (Please use ICD-10 Code for Diagnoses)							
Diagnosis 1: _____				Diagnosis 2: _____			
Additional related diagnoses: _____							
CEDAR Center: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?							
Does your child receive HBTS services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?							
Does your child receive PASS services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?							
Transportation Requested <input type="checkbox"/> No <input type="checkbox"/> Yes Pick-up/Drop-off will be at Johnston High School this year.							
Camp Cost: \$475.00 for the week <i>plus</i> \$75.00 non-refundable deposit (Total = \$550.00) (Please note, RI Medical Assistance - Katie Beckett, Rite Care, SSI - does not pay for camp.)							
Please note: If it is determined that your child needs 1 to 1 support and does not have RI Medical assistance or is over the age of 21, there will be an additional cost of \$550.00							
Please complete the "Payment Information" portion of this application to indicate how the payment will be made (page 11). There are a limited number of Camperships available based on a sliding scale. You may request an application which you will submit with a copy of your W2(s). Please contact Abby Waite at 401-785-2666 ext. 76797 for a Campership application.							

The Autism Project Summer Camp 2021

CAMPER PROFILE

Camper's Name	DOB	Date	
<i>Please complete the following sections and provide as much detail as possible. This information will help us create a successful experience for your child.</i>			
Please check all items that apply to child's present health. Thoroughly explain any checked answers.			
ALLERGIES (list below): <input type="checkbox"/> No known allergies			
<input type="checkbox"/> Food (include any dietary restrictions):			
<input type="checkbox"/> Insects/Plants:			
<input type="checkbox"/> Medicine Allergies:			
Treatment for any of the above that The Autism Project may need to perform. <input type="checkbox"/> Epi Pen **Doctor's order required** <input type="checkbox"/> Other:			
Medications: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list the medications below. Please indicate if a medication must be administered at camp. If yes, **a doctor's order is required** .			
		<input type="checkbox"/> Admin at camp	Time:
		<input type="checkbox"/> Admin at camp	Time:
		<input type="checkbox"/> Admin at camp	Time:
Physical limitations: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:			
Recent history of hospitalization or other important information for Camp Nurse to know:			
<i>Please complete the following information, if an emergency arises and we must contact you. Include information about how to reach you or another designated person during camp hours.</i>			
Emergency Contact Name	Relationship	Work Phone	Cell Phone
Emergency Medical Information			
Name of Physician:		City:	Phone:
Hospital of Choice:			
<i>In case of emergency, I understand that every effort will be made to contact me, or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 911 protocol.</i>			
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			

Camper's Name:

Past Camp Experience (If yes, please provide camp name):

Child's Likes: **Child's Dislikes:**

(favorite movies, characters, foods, games, music...etc.) (sounds, smells, touch, movement, foods etc.)

Does your child use any of the following strategies?

<input type="checkbox"/> Visual schedules	<input type="checkbox"/> Social Stories	<input type="checkbox"/> Conversation Scripts
<input type="checkbox"/> Choice Zone Worksheet	<input type="checkbox"/> Problem Solving Worksheets	<input type="checkbox"/> Contingency Mapping
<input type="checkbox"/> Thera-tubing	<input type="checkbox"/> Fidgets: _____	<input type="checkbox"/> Headphones: _____
<input type="checkbox"/> Chewing Gum	<input type="checkbox"/> Brushing Protocol	<input type="checkbox"/> Joint Compressions
<input type="checkbox"/> Relaxation Protocols: _____		
<input type="checkbox"/> Weighted Blanket/Vest		
<input type="checkbox"/> Other:		

Please describe your child's skill level:

	Complete Assistance	Partial Assistance	Independent	Comments:
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not yet trained –please tell us your child's habits and required supports so we may ensure his/her comfort and privacy.
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swimming	<input type="checkbox"/> w/floatation	<input type="checkbox"/> w/floatation	<input type="checkbox"/>	

My child exhibits the following behaviors:

<input type="checkbox"/> Runs away	<input type="checkbox"/> Touches other inappropriately	<input type="checkbox"/> Scratches, bites, hits self
<input type="checkbox"/> Scratches, bites or hits others	<input type="checkbox"/> Screams	<input type="checkbox"/> Other:

Does your child exhibit any of the following? If yes, please describe.

Self-regulation behaviors Yes No _____

Repetitive play or rituals Yes No _____

Reaction to change Yes No _____

How do you respond to these actions?

When my child gets anxious, she/he:

When my child is excited, she/he:

When my child gets frustrated, she/he:

Camper's Name:				
COMMUNICATION <i>Circle one:</i> Verbal Non-Verbal				
Does your child:	Independent	With help	Not yet	Comments:
Follow non-verbal directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follow verbal directions within familiar routines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follow verbal directions within novel activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Utilize visual supports to follow directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use pictures/sign language/ or other augmentative communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Require processing time to follow directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Make requests for basic wants and needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Comment on environment or the unexpected (oops!)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Converse with peers/ adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL DEVELOPMENT				
Does your child:	Independent	With help	Not yet	Comments:
Engage in solitary play?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Play same toy alongside peers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Engage in group play?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share materials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Take turns with peers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EMOTIONAL DEVELOPMENT				
Does your child:	Independent	With help	Not yet	Comments:
Request a break when upset?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Express feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indicate relaxation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Request assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Accept help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Express confusion ("I don't know")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indicate likes/dislikes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respond to praise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Camper's Name:				
Does your child:	Independent	With help	Not yet	Comments:
Make transitions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognize personal belongings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Organize needed materials for outings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Make choices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wait when directed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Adapted from Kathleen Ann Quill's Assessment of Social and Communication Skills for Children with Autism

<p>Please describe your child socially. Include age of peers he/she enjoys; interests; games enjoyed; activities enjoyed; speaking style; etc.</p>
<p>Please describe your child's communication, including any strategies that are helpful to assist in your child's comprehension.</p>

Camper's Name:

Please attach a photo of your child here.

Please add any comments you feel staff should know and areas of concern for supporting your child at camp. We host campers of all abilities and the more information we have, the better prepared our staff will be to ensure your child has a positive and fun experience.



Lifespan

Interview Video Photography Broadcast
Date: 2021

**Authorization and Release
For Photography/Audio and Videotaping/
Broadcasting/Interviewing
(When Protected Health Information is Involved)**

Initial Use: The Autism Project's Camp Wannagoagain!

Patient description _____
use if multiple patients photographed for initial use. Ex yellow shirt, tall, etc.

Patient Name (please print): _____

Patient Address (city/state zip): _____

Patient Date of Birth: _____ **Patient Phone #:** _____ **Patient Email:** _____

As applicable and as further described below, I authorize Lifespan and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction"). Describe nature of Permitted Interaction (i.e., context of interview, event at which photos are to be taken, etc.) and nature of protected health information to be gathered about patient:

Pictures and videos taken during Camp Wannagoagain and related activities. Photos/videos may be used on TAP's website, Facebook or Twitter accounts, or for training purposes. They may also be used for publicity in local papers and / or on the website to publicize the camp and related activities.

I authorize the Lifespan Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media for advertising, marketing, fundraising, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).

I authorize Lifespan and its affiliates to copyright any photographs, videos, and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.

I understand that, to the extent the content of the Permitted Interaction contains my protected health information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I understand that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan from all liability arising from this disclosure of my health information.

I understand this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:

Lifespan Marketing and Communications
117 Ellenfield Street, Suite 100
Providence, Rhode Island 02905

I understand that any previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Lifespan.

This form must be fully complete before signing.

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name

Print Name of Legal Representative (if applicable)

Relationship to Patient



Summer Camp 2021 PERMISSION FOR RESTRICTIVE PROCEDURES

Participant:	DOB:
<p>The Autism Project uses evidenced-based strategies that are designed to establish a safe and supportive environment, which will prevent your child from having behavioral difficulties. However, there may be rare occasions when the physical safety of a child, other participants, and staff is at risk. When this type of incident occurs, it may be necessary to physically hold your child to prevent harm, and to help her/him feel safe. Trained staff will only use a therapeutic hold in which your child is seated in a chair or on the floor and held in a “wrap” from behind. The hold is only maintained for as long as it takes for your child to begin to regain emotional and physical control so that he/she can move to a quieter area until they are able to rejoin the group. If it is necessary to move your child to a safe area before he/she has regained control, two staff members will use an approved escort procedure. These procedures are carried out in a calming, supportive, and non-punitive manner. You will be notified when you pick up your child of the intervention so that you can assist staff in processing the incident and supporting your child.</p>	
<p><i>I understand that the above procedures will be implemented only for the purpose of safety and control and in accordance with the stated guidelines. I authorize that the seated wrap or two-person escort will not compromise the medical safety of my child.</i></p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



Summer Camp 2021 PERMISSION TO PICK UP CHILD

Child:	DOB:		
Parent:	Date:		
Address:	Phone:		
Please complete the following information if someone other than yourself may pick up your child from Camp. You must notify us in advance of who will be picking up your child. Please note that we may ask that person to present valid identification to verify his/her identity before releasing your child to him/her.			
Name	Address	Relationship	Phone #
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			

Request for Transportation

- I will provide transportation to and from Camp *WANNAGOAGAIN!*
- I would like to have transportation, provided by the Autism Project, from the Johnston High School parking lot, 2850 Ministerial Road, West Kingston, RI 02892 and back. **I agree to pay the \$100 transportation fee for the week.** **Please indicate your interest now. We will inform you of availability when we know if we can offer transportation this year.*

Please provide a unique **CODEWORD** to utilize upon pick-up: _____

Please provide this unique **CODEWORD** to persons picking up your child from Camp. They will be asked for this codeword (by staff) to further verify identification before releasing your child.

Signature of Parent/Guardian: _____ Phone #: _____



PAYMENT INFORMATION (Confidential)

Tuition for camp only: \$550.00

For 1:1 (if not covered by Medicaid): Additional \$550.00

Bus Transportation by The Autism Project: Additional \$100

Camper Name:		SS#:		<i>(Required)</i>	
Parent Name:			Medicaid ID#:		
Billing Address:					
City:		State:		Zip:	
Registration Fee (\$75.00) required *Fee must be paid before registration can be processed.					
<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover <input type="checkbox"/> PayPal					
For Credit cards, Card #				Exp. Date:	
Cardholder's Name:					
Cardholder's Billing Address:					
City:		State:		Zip:	
				*Security Code:	
Method of payment for Camp Tuition: \$475 (after \$75 Reg. Fee is paid) Total: \$550					
(Will be processed when camper is placed.)					
<input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover <input type="checkbox"/> Purchase Order from School <input type="checkbox"/> PayPal					
For Credit Cards, Card #				Exp. Date:	
Cardholder's Name:					
Cardholder's Billing Address:					
City:		State:		Zip:	
				*Security Code:	
<input type="checkbox"/> Camp \$475.00 (\$550.00 total including \$75.00 Registration Fee)					
<input type="checkbox"/> 1:1 \$550.00 (if not covered by RI Medical Assistance Program/Katie Beckett Waiver)					
<input type="checkbox"/> Transportation \$100 (includes pick-up and drop off from Johnston High School, 345 Cherry Hill Road)					
Total Payment \$ _____					
Camperships available for camp tuition, 1:1 fees and transportation.					
<i>I authorize The Autism Project to process my payment as indicated above.</i>					
Parent/Guardian Signature:				Date:	

<input type="checkbox"/> Campership Program Camperships are available on a sliding scale. A scholarship application must be submitted with verification of family income (2018 W2, 2018 tax return, 2 recent pay stubs of all household income, etc.).

FOR OFFICE USE ONLY		
Payment Received: ___ / ___ / ___ \$ _____	Initials: _____	Campership award: _____
Registration and/or Total Tuition (circle)	Check#: _____	Parent Portion: _____

Demographic Survey: Camper (s)

Information is requested for data purposes only. Please do not include you or your child's name on this form

Participant's Sex male female other prefer not to answer

Participant's Age 5-8 9-12 13-16 17-20 21 and up (Please specify) _____

Household Income Range (Please consider all who live in and contribute money to the household)
 \$0-\$19,999 \$20,000-\$34,999 \$35,000-\$49,999 \$50,000+ prefer not to answer

Race (please check all that apply) American Indian or Alaska Native African American or Black
 Asian Native Hawaiian or Other Pacific Islander White prefer not to answer

Ethnicity (please check one) Hispanic or Latino or Spanish Origin^a Not Hispanic or Latino or Spanish Origin prefer not to answer

^a Defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Primary Diagnosis (Child 1) Autism Spectrum Disorder Autism Childhood Disintegrative Disorder
 Retts Syndrome Fragile X Non-Verbal Learning Disorder PDD PDD-NOS
 High Functioning Autism Asperger Syndrome Downs Syndrome Intellectual Disability
 Developmental Disability Other _____

Primary Diagnosis (Child 2) Autism Spectrum Disorder Autism Childhood Disintegrative Disorder
 Retts Syndrome Fragile X Non-Verbal Learning Disorder PDD PDD-NOS
 High Functioning Autism Asperger Syndrome Downs Syndrome Intellectual Disability
 Developmental Disability Other _____

Preferred Language spoken in your home:

English Spanish Portuguese Arabic Creole Swahili Hindi Mandarin
 Other _____ prefer not to answer

Office Only:

Camp *WANNAGOAGAIN!* 2021

Dates Attended: _____

SUMMER CAMP DEADLINE INFORMATION

Please keep this page for future reference

JUNE 11, 2021 DEADLINE FOR ALL CAMP REGISTRATIONS

JULY 9, 2021 LETTERS CONFIRMING PLACEMENT MAILED

JULY 23, 2021 TOTAL CAMP PAYMENT DUE

CAMP SESSION ONE:

August 9-13, 2021

Monday – Thursday from 9am – 3pm

Friday from 9am – 1pm

CAMP SESSION TWO:

August 16-20, 2021

Monday – Thursday from 9am – 3pm

Friday from 9am – 1pm

Registrations that are received after the above deadline or without the \$75.00 registration fee will result in your child being placed on a waitlist for an appropriate opening based on age and ability. We appreciate your understanding.

Please Note: All camp groups and times will be determined according to the deadline schedule. Due to the number of applicants, session dates cannot be chosen by families, but will be determined based on children’s ages and abilities. Thank you for understanding.

Please mail registration packet to:

**The Autism Project
Attention: Abby Waite
1516 Atwood Ave.
Johnston, RI 02919**

Or **e-mail** registration packet to Abby Waite at
abigail.waite@lifespan.org

We look forward to a fun summer at Camp *WANNAGOAGAIN 2021!*