



Chit-Chat Summer Camp Initial Application

Today's Date: _____

Background Information

Child's Full (legal) Name: _____ Date of Birth: _____

Sex: _____ Primary Language: _____ Other Language Spoken: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Child's T-shirt size (please specify child/adult): _____

Parent or Guardian Information:

Parent/Legal Guardian's Name: _____

Address: (check if same as address above) _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Mobile Phone: _____

First/Last Name of Family Member(s) who will be attending camp with child:

**Please note that parents/guardians are required to attend camp with child for a minimum of 3 out of 5 days. When parent/guardian is not present, an appropriate caregiver must be appointed to attend in their absence.*

Please provide information for any additional caregivers who will be attending camp with your child.

Additional Caregiver Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Mobile Phone: _____

Emergency Contact Available During Camp (other than family member(s) attending camp)

Name: _____ Relationship to Camper: _____

Address: _____

City: _____ State: _____ Zip: _____



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Day Phone: _____ Evening Phone: _____

Child's Medical Information

Diagnosis: _____

Medications: _____

Seizures:

- no
- yes type: _____ frequency: _____

Allergies (please specify): _____ Latex: ___yes ___no

Recent Illness: _____

Diet:

Foods:

- regular
- chopped
- blended-pureed

Liquids:

- regular
- thickened

Dietary Restrictions (e.g., low salt, low calorie, etc.): _____

Food Allergies: _____

Additional Diet Information: _____

Hearing:

- normal
- hearing impaired. Please describe deficit: _____

Vision:

- normal
- visually impaired. Please describe deficit: _____

Primary Care Physician's Information

Physician's Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Personal Care

Eating:

- no assistance needed
- some assistance for set-up
- partial assistance
- total assistance



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Mobility:

- walks
- wheelchair (manual)
- wheelchair (electric)

Please indicate any other additional adaptive equipment currently used:

- walker
- lap tray
- adaptive seating
- seat wedge
- head support
- chest or seat straps
- hand splints
- other: _____

Please indicate preferred position:

- regular chair
- wheelchair
- beanbag
- other: _____

Transfers:

- no assistance needed
- partial assistance
- total assistance
- two-person lift

Toileting:

- no assistance
- partial assistance
- total assistance

Please list aids used during toileting:

- needs reminders
- diapers/briefs
- toilet chair
- other: _____

Educational History

Current School Placement: _____

- inclusion classroom
- day school setting
- substantially separate classroom
- residential placement
- other: _____

Therapeutic Services

- speech-language therapy _____ (# of times) per week
- occupational therapy _____ (# of times) per week
- physical therapy _____ (# of times) per week

Additional Information:



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School Performance

What is his/her approximate developmental or grade level: _____

How is his/her performance in school? _____

Behavior/Learning Style

Works best:

- in 15 minute sessions
- in 30 minute sessions
- in individual sessions
- in group sessions
- with parent involved
- without parent involved
- with 1:1 behavior support
- with hand-over-hand support

Child's Interests/ Preferred Activities: _____

Present Communication Skills

How does the child presently communicate? (please check all that apply)

- speech - How many words? _____ Please provide some examples: _____

How well do you understand the child's speech? ___good ___fair ___poor

How is the child's volume of speech? ___good ___fair ___poor

- vocalizations
- eye gaze
- facial expressions
- gestures
- sign language- How many signs does he/she use? _____
Please provide some examples: _____
- Picture Communication Book
- Picture Exchange Communication System (PECS)
- alphabet board
- augmentative communication device

Does the child understand what is said to him/her most of the time?

- yes
- no

Does the child have a reliable Yes/No response?

- yes
- no

What is his/her current level of understanding? (check all that apply)

- comprehends single words
- understands simple sentences and 1-2 step directions
- follows multi-step directions



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- comprehends conversation

AAC System Use (please check all that apply):

- child uses system spontaneously and interactively
- initiates communication with AAC system
- uses system to answer questions
- needs to be directed to use system
- single key is used to express a full message
- sequences symbols/single words to form messages
- demonstrates functional spelling skills
- uses system to back-up speech or sign language

Communication Equipment

Device Name: _____

Application software program (if applicable): _____

How does the child access the device (Please explain):

direct selection: _____

scanning: _____

switch type: _____

access site: _____

switch accuracy (estimate % correct): _____

Please briefly describe the organization of the child's device (e.g. # of pages or levels, # of pictures or words per overlay/page):

Is the device mounted to a wheelchair?

- yes
- no

How long has the child had the device? _____

Device Use/Performance (please check all that apply):

Child uses device:

- in structured school activities
- in therapy
- with a printer or computer as a writing aid
- spontaneously at home for social interaction
- spontaneously at home for directed tasks
- spontaneously in the community

Parent's AAC Skills

Parent's knowledge of the device:

- new device/basic skills
- can operate
- can program



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- can customize
- unsure of how to use/program device

Parent Training Needs/Suggestions:

Parent Goals/Expectations from Camp:

1. _____
2. _____
3. _____

Are you interested in billing camp therapy services through private insurance?

- No
- Yes

Insurance Information

Primary Insurance Type: _____ Policy #: _____

Name of Policy Holder: _____ DOB: _____

Social Security Number of Policy Holder: _____

Secondary Insurance Type: _____ Policy #: _____

Name of Policy Holder: _____ DOB: _____

Social Security Number of Policy Holder: _____

Person/Agency Responsible for Funding Camp (other than private insurance):

Name: _____

Contact Information:

Please also attach copies of the following:

- Most current IEP or treatment plan



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- ❑ Most recent evaluations (e.g. speech-language therapy, occupational therapy, physical therapy reports, if appropriate)
- ❑ A photo of your child
- ❑ **If your child is using customized page sets on his/her device, copies of these pages are requested**

Please send completed form and requested materials to:

**Rebecca Therriault, M.S., CCC-SLP
Speech-Language-Hearing Department
C/O ACAT Camp
Franciscan Hospital for Children
30 Warren Street
Brighton, MA 02135**