Dustin's Place Intake Application

Camper full name:

DOB/ grade attended:

Camper address:

City, State, Zip:

Parent/Guardian name: Relationship:

Parent/Guardian email:

Parent/Guardian address:

City, State, Zip:

Parent/Guardian Phone:

Emergency contact (other than guardian) name:

Emergency contact phone:

Camper diagnosis:

Returning Families, please note any changes in your child's needs or functioning below.
New Families, please complete fully.

Camper's strengths (academic, social, behavioral, emotional):

Camper's difficulties (academic, social, behavioral, emotional):

Your goals for your child:

Allergies:

Dietary needs:

Medications:

Physical difficulties:

Motor functioning:

Sensory Integration Issues:

Swimming experience/ability:

Hygiene: (Please circle one)

Brushing teeth- Completely independent Needs prompts Needs assistance

Showering- Completely independent Needs prompts Needs assistance

Toileting- Independent Needs prompts Needs some assistance Bedwetting Needs no assistance

Any other prompts needs for hygiene? Please explain

Has your child attended sleep-away camp in the past? ☐ Yes ☐ No

Has your child spent the night away from home? ☐ Yes ☐ No

What where these experiences like for the child?

Sleeping: (Please circle if it applies) Sleepwalker Difficulty going to sleep Snores Fear of dark Nightmares Needs nightlight Needs bathroom close Uses CPAP machine

What are situations that your child finds challenging, and what have you found to be effective to manage the situation?

What specific activities help soothe and calm your child?

What physical or verbal signs do your child exhibit when he/she is becoming anxious, and what works to help manage the situation?

Communication: (Please circle one)

Communicates clearly Can be difficult to understand Processes slowly Speech is moderately affected

Makes only sounds Nonverbal Other (Please explain)

Please list your child's treatment history:

Does your child have a history of any of the following:

Physical aggression:	☐ Yes	☐ No
Emotional aggression:	☐ Yes	☐ No
Requiring physical restraint:	☐ Yes	☐ No
Sexual acting out:	☐ Yes	☐ No
Self-harm or ideation:	☐ Yes	☐ No
Running away:	☐ Yes	☐ No
Behavior dangerous to self or others	☐ Yes	☐ No
Difficulty with toileting or bed wetting	☐ Yes	☐ No

If the answers to any of the above are yes, please explain:

Last instance:

Frequency:

Intensity:

Duration:

Are there any other issues you feel we need to be aware of?

How did you hear of us?

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☐ Yes ☐ No | Staff may photograph participants before, during or while on the therapeutic course. I grant Aerie Experiences and persons acting for or representing Dustin's Place or Aerie Experiences the right to use, reproduce, assign, and/or distribute photographs, film, videotapes, and sound recordings of the participants for use in materials they may create.

***Parent/Guardian Signature**: Date:

Program Selection

Please check intended programs:

- ☐ Summer Ranch Adventure Camp, Week 1- June 1-7, 2019
- ☐ Summer Ranch Adventure Camp, Week 2- June 9-15, 2019
- ☐ Summer Ranch Adventure Camp, Week 3- June 18-24, 2019 GIRLS ONLY without disabilities

Payment Information:

All summer camps are $1200.00 per camper. If you sign up before April 1st, 2019 you receive $100 off.

A $500 deposit is required to secure summer camp space; all deposits for summer camp are non-refundable. No refunds are offered on deposits.

Campers can stay on the ranch between sessions. There is a $100 fee for each stay over day between ranch sessions.

Checks should be made out to **"Brecht Stables"**

Credit card payments (we accept Master Card, VISA, Amex):

Amount to be charged:

Card Type:

Card Number:

Name on Card:

Expiration Date:

Security Code:

Billing Address:

*Signature authorization to charge card:

Email completed applications to lynn@brechtstables.org. Mail hard copy applications with check payment to Brecht Stables 6580 Riley Rd Cumming, GA 30028

To help us better identify your child's strengths please include a copy of their most recent formal psychological and educational testing.

CONSENT FOR RELEASE OF INFORMATION

Name of Dustin's Place Program Participant:

Dustin's Place is authorized to release and/or receive verbal and/or written information regarding treatment planning, progress in treatment, aftercare recommendations and discharge summaries regarding the patient listed above.

Pursuant to 45 C.F.R., Section 164.508 of the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the disclosure of my protected health information as described above. I understand that these records may be protected under other federal and state privacy regulations as well. I also understand that these records cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization is provided to you voluntarily. Once it is released, the information may no longer be protected by HIPAA or other state and federal regulations. I am aware that I may revoke this authorization at any time by notifying you in writing, except to the extent that you have taken actions in reliance of it and that any event this consent expires automatically as indicated below.
I further release all parties named herewith from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise sufficient safeguards while using this information.

Please check all that apply:

☐ Phone Contact ☐ Discharge Summary ☐ Psychiatric Records ☐ Psychological Testing
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ School Teacher

*Applicant Signature: Date:

Name:
Nature of Service:
E-mail Address:
Fax number:
Telephone number: Dates of service:

Name:
Nature of Service:
E-mail Address:
Fax number:
Telephone number: Dates of service:

Name:
Nature of Service:
E-mail Address:
Fax number:
Telephone number: Dates of service:

List any and all individuals or service providers who may have worked with the applicant and/or family, and sign the release form so that we may communicate with them. If the applicant has attended a treatment center, hospital, or other program, please include this information. This includes Psychologists, Medical Doctors, Education Counselors, Therapists, Boarding Schools, Foster Homes, Treatment Centers, In-patient Programs, family members (if applicant is 18 or over):