



Aerie Experiences 2017 Program 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:

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?

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?



Describe your child's ability to communicate:

Please list your child's treatment history:

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

- | | | |
|---|------------------------------|-----------------------------|
| Physical aggression: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional aggression: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Requiring physical restraint: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sexual acting out: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Self-harm or ideation: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Running away: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Behavior dangerous to self or others: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty with toileting or bed wetting: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child sexually active: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

Last instance:

Frequency:

Intensity:

Duration:

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



Yes No | Staff may photograph participants before, during or while on the therapeutic course. I grant Aerie Experiences and persons acting for or representing Aerie 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:

Respite and Adventure Weekends

- | | | |
|---|---|-------|
| <input type="checkbox"/> Winter Ranch Adventure | Feb 17th – Feb 20 th | \$625 |
| <input type="checkbox"/> Spring Mountain Mayhem | March 31st – April 2 nd | \$425 |
| <input type="checkbox"/> Spring Southern Paddle | May 5 th – May 7 th | \$475 |
| <input type="checkbox"/> Fall Trout and Target | Sept 29 – Oct 1 | \$425 |

Summer Camps

- | | |
|--|---|
| <input type="checkbox"/> River Expedition Camp | June 5 th – June 11 th |
| <input type="checkbox"/> Coastal Expedition Camp | June 18 th – June 24 th |
| <input type="checkbox"/> Ranch Camp I | July 1 st – July 7 th |
| <input type="checkbox"/> Ranch Camp II | July 9 th – July 15 th |
| <input type="checkbox"/> Ranch Camp III | July 17 th – July 23 rd |

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

Payment Information:

All summer camps are \$2,400 per camper. A 10% discount will be applied for all summer camp registrations **paid in full** prior to March 15, 2017.

A \$500 deposit is required to secure summer camp space; all deposits for summer camp are non-refundable. No refunds are offered for cancelations after May 1, 2017. Balance of payment is due May 1, 2017.

Checks should be made out to “**Aerie Experiences**”



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 mdweneta@aerieexperiences.com. Mail hard copy applications with check payment to Aerie Experiences, 2810 Lullwater Drive, Gainesville, Ga. 30506

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 Aerie Experiences Program Participant: _____

Aerie Experiences 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

*Applicant Signature: _____ Date: _____

*Parent/ Guardian Signature: _____ Date: _____

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):

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: