Print Form

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Aerie Experiences 2020 Program Application

Camper full name:			
Date of Birth:			Grade attended:
Camper address:			
City:	State:	Zip:	
Parent/Guardian name(s):			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:

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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 does your child exhibit when he/she is becoming anxious, and what works to help manage the situation?

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Describe your child's ability to communicate:

Please list your child's treatment history and diagnosis(s):

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
Is your child sexually active:	☐ Yes	☐ 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?

How did you hear of us?

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

2020 Program Selection: Please check intended programs:

Adult Winter Ranch

☐ ADULT Winter Ranch	Dec. 22 – Jan. 2	$650

Respite and Adventure Weekends

☐ Winter Ranch Adventure	February 14 – 17	$650

Summer Sleep Away Camps

☐ Coastal Expedition	June 7 – 13	$2400
☐ Llama Farm Adventure I	June 19 – June 25	$2400
☐ Llama Farm Adventure II	June 27 – July 3	$2400
☐ Ranch Camp I	July 11 – July 17	$2400
☐ Ranch Camp II	July 19 – July 25	$2400

- Campers can stay on the ranch between sessions. There is a $150 fee for each stay over between ranch sessions. Laundry service is provided.
- A 10% discount will be applied for all summer camp registrations **paid in full** prior to February 1, 2020.

Payment Information:

A $500 deposit is required to secure summer sleep away camp space (per session). A $150 deposit is required to secure summer day camp space (per session). All deposits for summer camps are non-refundable. No refunds are offered for cancelations after May 1, 2020. Balance of payment is due May 1, 2020.

Checks should be made out to **"Aerie Experiences"**

Credit card payments (we accept MasterCard, VISA, AMEX & Discover):

Amount to be charged:

Card Type: AMEX

Card Number:

Name on Card:

Expiration Date: Security Code:

Billing Address:

City: State: Zip:

*Signature authorization to charge card:

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Email completed applications to mdweneta@aerieexperiences.com
Or mail hard copy applications to:
Aerie Experiences
6011 Sycamore Road
Buford, GA 30518

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, videotape, and sound recordings of the participants for use in materials they may create.
☐ **Yes** ☐ **N**

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

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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:
Telephone number: Fax number:
Dates of service:

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

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