



Background Information:

Date: _____

Child's Name: _____ Sex: _____ Birth Date: _____

First/Last Name of parent(s) attending camp: _____

Address: _____

Street

City, State Zip

Home Phone: _____ Work Phone: _____

E-mail: (please print clearly) _____

Medical Diagnosis: _____

School Name: _____

Address: _____

Street City, State, Zip

Educational Classification: _____ Estimated Grade Level: _____

Indicate Preference for Camp Program: *Note: Siblings must be at least 7 years of age, be able-bodied and not be educationally classified.

Parent/Child _____ **Family** _____

Expectations for Camp Chatterbox Program: (check all that apply)

- Enable my child to have a fun camp experience
- Help motivate my child to use his/her device
- Provide my child with opportunities to communicate and the time needed to succeed when using his/ her device
- Have my child meet other children who use AAC devices
- To increase my child's initiated use of the device
- As a parent, to improve my skills in _____ programming the device
_____ encouraging my child to use his/her device
- Other – please specify: _____

Person/Agency Responsible for Funding Camp:

Contact Person, Name/Phone #

Street, City, State, Zip

Present Communication Skills:

Primary mode of communication: _____
 Yes/No Response: _____ Reliable _____ Inconsistent
 Language Comprehension Level: _____
 Verbal Abilities: _____ No speech _____ Some understandable speech

AAC System Performance:

_____ 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 full message
 _____ Sequences single words to form messages
 _____ Demonstrates functional spelling skills
 _____ Uses system as a back-up to speech/sign

Communication Equipment:

Device Name: _____

Device page set: (if applicable) _____

How does the child access the device: (please explain) _____

Direct Selection: _____ Scanning: _____

Switch Type: _____ Access Site: _____

Switch Accuracy (estimate % correct) _____

Briefly describe vocabulary organization of child's device: (e.g. # of pages or levels; # of pictures or words per overlay)

Is the device mounted to a wheelchair? _____ Yes _____ No

How long has the child had the device? _____

Are there any problems with seating and positioning that you need to address prior to camp?
 _____ Yes _____ No

If yes, specify: _____

Device Use/ Performance (Check all that apply)

Child uses device:

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

Behavior/ Learning Style – Works best in:

_____ 15 minutes sessions _____ 1/2 hour sessions
 _____ individual sessions _____ group sessions
 _____ w/ parent involved _____ w/out parent involved
 _____ w/ 1-1 behavioral support _____ w/ hand-over-hand support

Medical Information:

Known Allergies: _____ Latex: ___ Yes ___ No Recent Illness: _____

Seizures: _____ Medications: _____

Personal Care:

Is child continent? : _____

Toileting:	_____ independent	_____ needs assistance	_____ dependent
Feeding:	_____ independent	_____ needs assistance	_____ dependent
Mobility:	_____ ambulatory	_____ manual chair	_____ power chair

Parent Knowledge of the Device:

New device/basic skills: _____ Can operate: _____

Can program: _____ Can customize: _____

Parent Training- List Needs/Goals/Suggestions for Camp Parent Training Sessions:

1. _____
2. _____
3. _____

PLEASE INCLUDE:

1. A copy of your child's current Speech, OT and PT reports
2. A videotape or standard size DVD of child using his/her AAC device. Follow guidelines as specified in this packet
3. If your child is using customized page sets, a copy of these pages are requested.

**ALL INFORMATION AND THE VIDEOTAPE MUST BE RECEIVED PRIOR TO
ACCEPTANCE IN THE CAMP PROGRAM.**

Send completed form, support materials, video and a \$300 deposit to:

**Joan Bruno, Ph.D., CCC-SLP, Director
Educational Technology Department
c/o Camp Chatterbox
Children's Specialized Hospital
150 New Providence Road
Mountainside, NJ 07092
(908) 301-5451**

(*Note: Your deposit will be returned if your child is not accepted into the program.)

2009

CAMP CHATTERBOX - REGISTRATION SUMMARY

Please indicate ONLY the names of family members who will be attending Camp.

Camper's Name: _____ T-shirt Size: CS_ CM_ CL_ AS_ AM_ AL_ (free)

Mother's Name: _____ Father's Name: _____

Sibling's Name: _____ Age: _____ Sex: M ___ F ___

Sibling's Name: _____ Age: _____ Sex: M ___ F ___

Sibling's Name: _____ Age: _____ Sex: M ___ F ___

Therapy Fee = \$550.00 \$550.00

Parent/Child = \$300.00 _____

Family fee 3 = \$550.00 (mom+dad+camper **or** parent+sibling+camper) _____

Family fee 4 = \$740.00 (mom, dad, 1 sibling, camper) _____

Additional Sibling = \$250.00 each _____

Subtotal = _____

T-SHIRT ORDER

(Please note that while you are not required to purchase a t-shirt, most people want them for T-shirt day. T-shirts will NOT be available for purchase at camp.)

I am ordering _____ **additional** Camp Chatterbox T-shirt(s)

___ Child small @ \$10.00 each ___ Child med. @ \$10.00 each ___ Child large @ \$10.00 each

___ Adult small @ \$12.00 each ___ Adult med. @ \$12.00 each ___ Adult large @ \$15.00 each

___ Adult X-Large @ \$15.00 each ___ Adult XXL @ \$15.00 each

T-shirt Subtotal: \$ _____

Total Amount = \$ _____

Less Deposit = \$ 300.00

AMOUNT DUE \$ _____

RETURN THIS FORM WITH YOUR APPLICATION



CHILDREN'S SPECIALIZED HOSPITAL
 Videotape/Photograph Release Form

I hereby grant permission to Children's Specialized Hospital to obtain videotapes and/or photographs of me/my child (specify names below):

to be used by the hospital for promotional and marketing activities including the Camp Chatterbox website, and conference presentations. I understand that the videotapes and/or photographs become the property of Children's Specialized Hospital. I will not request nor receive any remuneration for these videotapes and/or photographs. I understand that my name and that of my child may be used.

 Signature of Parent/Legal Guardian Date

 Witness Date

RETURN THIS FORM WITH YOUR APPLICATION

Video Requirements

1. The video should be approximately 10 -15 minutes long.
2. It may be sent in on a standard size CD or DVD or standard size VHS. We are *unable* to view videos taped using the 8mm format or the mini DVD.
3. The video must show the child independently using his/her primary communication device. This can be either a manual board or a high tech device. For this segment, the camera should be focused far enough away from the child to show how the child is making selections on his/her system. It should also include a close-up of the screen of the device and a close-up of the child accessing his/her switch.
4. Please include clips of the following:
 - a. The child answering a series of questions for which each question has a targeted answer (e.g., What color is snow?; You see with your?; Name something you can read? etc.)
 - b. A demonstration of the child's "typical" use of the device.
 - c. A sample of home and school device use is desired, but not required.
 - d. A sample which demonstrates whether the child is combining single words to create messages or using a single button to make a sentence.
5. Copies of a sampling of the child's screens or overlays would be appreciated.