



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.



Camp Chatterbox Medical History Form

CAMPER

I. GENERAL INFORMATION

Name _____ Birthdate _____ Sex ____ Age _____

Parent/Guardian _____

Address _____ Phone _____

Neurologic/Genetic Diagnosis (etiology of communication/language disorder):

NOTE: Please attach a copy of the medical records (i.e. consultations, MRI reports, chromosomal analysis) which confirm this diagnosis.

Home Emergency Contact _____ Phone _____

II. CURRENT MEDICAL STATUS

Current Medications: _____

Allergies: _____

Latex Allergy: ____ Yes ____ No

Dietary Restrictions: **Please attach a copy of child's immunization record.**

Date of Last Tetanus Shot: _____

Medical Problems (ear infections, seizures, asthma, etc.):

Serious Illnesses / Injuries (list type/date/hospitalizations):

Primary Physician Name/Phone Number:

III. BIRTH HISTORY

Length of Pregnancy (full term or premature) _____ (weeks/months)

Pregnancy Complications, if any:

Hospital:

Delivery: Spontaneous vaginal ____ Induced ____ C-section ____

Complications during Delivery, if any:

Birth Weight: _____

Did your child require care in the intensive care nursery? ____ yes ____ no

How old was your child when he/she came home from the hospital? _____



Camp Chatterbox Medical History Form

FAMILY

The camp facility requires basic medical information be on file for each person attending Camp Chatterbox. Please use this form to provide information on all adults and siblings in attendance.

GENERAL FAMILY INFORMATION

Last Name: _____

Address _____ Phone _____

Who should be contacted at your home in case of emergency?

Name _____ Phone _____

FAMILY MEMBER 1

First Name _____ Birthdate _____ Sex _____

Age _____

Date of Last Tetanus Shot: _____

Please attach a copy of immunization record, if available

Current Medications:

Allergies:

Latex Allergy: yes no

Dietary Restrictions: _____

Primary Physician Name/ Phone Number:

FAMILY MEMBER 2

First Name _____ Birthdate _____ Sex _____

Age _____

Date of Last Tetanus Shot: _____

Please attach a copy of immunization records, if available

Current Medications:

Allergies:

Latex Allergy: yes no

Dietary Restrictions: _____

Primary Physician Name/Phone Number:

FAMILY MEMBER 3

First Name _____ Birthdate _____ Sex _____
Age _____

Date of Last Tetanus Shot: _____

Please attach a copy of immunization records, if available

Current Medications:

Allergies:

Latex Allergy: ____ yes ____ no

Dietary Restrictions _____

Primary Physician Name/ Phone Number:

FAMILY MEMBER 4

First Name _____ Birthdate _____ Sex _____
Age _____

Date of Last Tetanus Shot: _____

Please attach a copy of immunization records, if available

Current Medications:

Allergies:

Latex Allergy: ____ yes ____ no

Dietary Restrictions _____

Primary Physician Name/ Phone Number:

FAMILY MEMBER 5

First Name _____ Birthdate _____ Sex _____
Age _____

Date of Last Tetanus Shot: _____

Please attach a copy of immunization records if available

Current Medications:

Allergies:

Latex Allergy: ____ yes ____ no

Dietary Restrictions: _____

Primary Physicians Name/ Phone Number:
