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Summer 2012

Dear Parents/Guardians:

In a continuing effort to provide a safe and quality recreation program, we have developed the following guidelines for acceptance into the after school program. Please be sure to review all guidelines **PRIOR TO** completing the application for admission.

1. **ALL** information on the application must be completed truthfully and accurately.
2. Children must be at least 5 years old at program start.
3. We may not accept participants that require skilled nursing care.
4. Acceptance into the program is provisional. A child may be released from the program if they cannot successfully function within the program's standards.
5. Children that have a history of violent behavior resulting in injury to themselves or others will not be accepted into or allowed to continue in the program.
6. Only orally administered medication can be given to a participant on a regular basis. Under no circumstances will any staff administer medication other than orally to a participant. If a participant requires any other medical treatment on an emergency basis, 911 will be called immediately. Staff is not trained to and **WILL NOT** provide any care or treatment other than standard first aid.
7. Participants must be able to successfully participate in the program with no greater degree of supervision than a 1:6 or 1:10 coach/participant ratio.
8. Guidelines in the policy and procedures handbook will be strictly followed.
9. Applications are considered on a first come, first served basis and waiting list will be established. Each site reserves the right to limit enrollment based on age and the child's ability level.
10. Please review the program fee instructions on the reverse side of this page for more information on the current fees for this summer. You must provide a copy of your lunch status letter if you feel you may qualify for a reduced rate.

The application process is as follows:

- a) Complete application and return in person or by mail to All People's Life Center, Citrus Park, Hunter's Green, or Plant City (Faxed applications **will not** be accepted)
- b) Receive acceptance letter or verbal notification.
- c) If accepted, complete registration and pay fees prior to child starting in the program.

We are looking forward to providing a positive recreation experience for our participants this summer! This can only happen with the assistance of parents and staff working together as a team. Please feel free to offer your comments or suggestions at any time to help improve our programs.

Sincerely,

The Therapeutic Recreation Staff

All People's Life Center, 6105 East Sligh Avenue, Tampa Florida, 33617 (813) 744.5978j

Post Office Box 1110 • Tampa, Florida 33601

www.hillsboroughcounty.org

An Affirmative Action/Equal Opportunity Employer

APLC	Turkey Creek Rec	Riverview HS	Chamberlain HS	Citrus Park Elem.	Heritage Elem
6105 E. Sligh Ave Tampa, FL 33617 6:00 pm 7:30 am – 6:00 pm	936 Connell Rd Plant City, 33556 1:00 pm-- 6:00 pm	11311 Boyette Rd Riverview, 33569 7:30 am – 6:00 pm	9401 North Blv Tampa, 3361 7:30 am – 6:00 pm	7700 Gunn Hwy Odessa, 33625 7:30 am – 6:00 pm	18201 E. Meadows Rd Tampa, 33647 1:00 pm--6:00pm

2012 CAMP SPARKS APPLICATION

(All Campers must be at least 5 years old)

(This document is subject to the Public Records Law, Chapter 119, Florida Statutes (2001) and may be open to inspection by third parties)

GENERAL INFORMATION

Child's Name: _____ Wheelchair User? Y N Power? Y N
 Address: _____ Phone #: _____
 City: _____ State: _____ Zip: _____
 Birthdate: _____ Age: _____ Height: _____ Weight: _____ Male: _____ Female: _____
 School: _____ Child's First Language: _____ T-Shirt Size Youth Adult
 Attending Summer School? Y N If so, what school? _____ S M L XL

PARENT/GUARDIAN NAMES

Mother's Name: _____ Home No. _____
 Employer: _____ Work No. _____
 Father's Name: _____ Home No. _____
 Employer: _____ Work No. _____
 Child lives with: Both Parents Single Parent (please name) _____
 Other (please name) _____
 Parents Email: _____

Please list all other persons who may pick up your child and/or will assume responsibility for your child if you cannot be reached: ID will be required from anyone picking up child other than parent.

Name: _____ Phone No. _____
 Name: _____ Phone No. _____
 Name: _____ Phone No. _____
 Name: _____ Phone No. _____
 Name: _____ Phone No. _____

PLEASE NOTE: A copy of a court decision must be on file if a child is NOT to be released to the non-custodial parent.

PRIMARY EXCEPTIONALITY (Check One)

<u> </u> Educable Mental Handicapped	<u> </u> Trainable MH	<u> </u> Severe/Profound MH
<u> </u> Spinal Cord	<u> </u> Spina Bifida	<u> </u> Amputee
<u> </u> Muscular Dystrophy	<u> </u> Cerebral Palsy	<u> </u> Dwarf
<u> </u> Visually Impaired	<u> </u> Hearing Impaired	<u> </u> Autistic

PHYSICIAN/HOSPITAL

Health Insurance Company: _____

Policy #: (Group) _____ (Individual) _____

Name that Appears on Policy: _____

Medicaid #: _____

Physician's Name: _____ Phone #: _____

SEIZURE INFORMATION

Does child have seizures? ____ Yes ____ No Are they controlled? ____ Yes ____ No

How long does seizure last? _____ Describe seizure: _____

Date of most recent seizure: _____

ALLERGY INFORMATION

Medication Allergies: _____

Food Allergies: _____

Other Allergies: _____

Latex Sensitivity/Allergy? ____ Yes ____ No

MEDICATIONS

Please list all medication camper takes (dosage/times): _____

Can camper administer medications to self during camp hours? ____ Yes ____ No

Please list and describe any other medical conditions: _____

I hereby represent that the above information provided by me is accurate to the best of my knowledge and I hereby acknowledge and agree to the terms and conditions set forth herein.

Signature

Date

COMMUNICATION

Verbalizes _____ Yes _____ No
Gestures _____ Yes _____ No
Sign Language _____ Yes _____ No
Eye Contact _____ Yes _____ No
Has Hearing Loss _____ Yes _____ No

Writing _____ Yes _____ No
Makes Sounds _____ Yes _____ No
Facial Expressions _____ Yes _____ No
Has Hearing Aid _____ Yes _____ No

Other information: _____

EATING

Right Handed _____ Yes _____ No
Drinks from Glass _____ Yes _____ No
Eats Table Food _____ Yes _____ No
Needs Food Cut _____ Yes _____ No

Feeds Self _____ Yes _____ No
Drinks from Cup _____ Yes _____ No
Needs Food Pureed _____ Yes _____ No
Small Bites _____ Yes _____ No

DIFFICULTIES

Tongue Thrust _____ Yes _____ No
Continual Sucking _____ Yes _____ No
Closing Mouth _____ Yes _____ No
Drinking _____ Yes _____ No

Gagging _____ Yes _____ No
Chewing _____ Yes _____ No
Swallowing _____ Yes _____ No
Stuffs Mouth _____ Yes _____ No

Other information: _____

PERSONAL HYGIENE/TOILETING

Needs Help Washing Hands _____ Yes _____ No
Has Menstrual Cycle _____ Yes _____ No
Requires Help with
Menstrual Cycle _____ Yes _____ No
Uses Potty Chair _____ Yes _____ No
Needs Help Wiping _____ Yes _____ No

Needs Help Dressing _____ Yes _____ No
Independent Toileting _____ Yes _____ No
Wears Diapers _____ Yes _____ No
Needs Help Wiping _____ Yes _____ No
Uses Standard Toilet _____ Yes _____ No
Needs Supervision _____ Yes _____ No

If wheelchair is used, he/she needs assistance to transfer. _____ Yes _____ No

Describe any other personal hygiene issues: _____

MOBILITY

Can Sit Alone _____ Yes _____ No
Can Roll Over _____ Yes _____ No
Stands _____ Yes _____ No
Runs _____ Yes _____ No
Good Arm/Hand Use _____ Yes _____ No
Dominant Hand _____ Right _____ Left

Holds Head Up _____ Yes _____ No
Crawls _____ Yes _____ No
Walks _____ Yes _____ No
Climbs Stairs _____ Yes _____ No
Has Splint(s) _____ Yes _____ No
Wheelchair User _____ Yes _____ No

BEHAVIORS

Pushes/Kicks Self or Others	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swears/Curses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scratches Self or Others	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bites Self or Others	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tears Magazines/Clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Throws Objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bangs Head or Body Parts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breaks Windows	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Takes Others Belongings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has Temper Tantrums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Public Exposure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cries Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Refuses to Comply to			Relates well to		
Requests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Strangers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constantly Jumps or Runs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Enjoys Being Hugged	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please describe how you handle a disciplinary problem: _____

Please describe any other unusual behaviors: _____

Other Information: _____

What activities/sports does your child enjoy?: _____

Describe positive behaviors and talents: _____

RELEASE OF RESPONSIBILITY: I hereby agree to release, discharge and hold harmless the Hillsborough County School Board, Hillsborough County Parks, Recreation and Conservation Department, Hillsborough County and its appointed officials, employees, agents and volunteers and the organizers and sponsors of the camp from any and all liabilities, claims, demands or causes of action, including, but not limited to, liabilities for personal injury, death or damage to property arising out of my child's/children's participation in the camp and its programs and activities and/or the transportation of my child/children to and from the camp's activities and programs except when caused by the sole negligence of the Hillsborough County School Board or Hillsborough County, its employees and/or agents.

MEDICATIONS: If I am to request Camp Sparks staff to give medication to my child during camp hours, I must provide the center with a completed medication authorization form signed by me. I further understand that medication **MUST** be in its original container and current. Under no circumstances will any staff give medication other than orally to a participant.

FIELD TRIPS: I give permission for my child to attend various pre-planned field trips and/or impromptu neighborhood walking field trips. I understand I will receive information in advance about the date, time, destination and cost of each pre-planned trip.

PHOTOGRAPHS: I grant/ do not grant full permission to Hillsborough County to take and use photographs, video tapes, motion pictures, recordings, or any other record of this program for any purpose and I relinquish and give to Hillsborough County all rights, title, and interest I may have in the above items.

Signature _____

Date _____

INFECTION CONTROL POLICY

In a camp setting children come into contact with groups of other children. It is in this situation that illness of one child can spread rapidly through the group to other children and staff members if stringent measures to prevent this spread are not taken. For this reason, the Camp Sparks staff will take precautions to prevent the spread of illness. Careful hand washing by staff and children can eliminate approximately 75% of the risk of spreading these illnesses. Other precautions include separating sick children from those who are not sick, taking extra precautions with diapers or toilet training children, and working to maintain sanitary conditions throughout the camp.

You, the parent, can help us in our effort to keep your child/ren in good health. We ask your cooperation in the following ways:

If your child shows any signs of the symptoms listed below, you will be called and asked to come immediately to get your child. Please help us to protect the other children by picking up your child **within one hour**. If your child has any of the following symptoms in school or at home, we ask that you keep him/her out of camp until the symptoms are gone or until your physician says it is alright to return. A written note from the physician is needed for the child to return after an extended (greater than 1 week) illness or contagious illness.

The symptoms include:

- Fever – 100 degrees or higher
- Yellowish mucous running from the nose
- Severe coughing – child makes high-pitched cough or whooping sounds
- Difficult or rapid breathing
- Yellowish skin or eyes
- Pinkeye – tears, redness of eyelid lining, followed by swelling and discharge of pus
- Sore throat or trouble swallowing
- Infected skin patches
- Grey or white stool
- Headache or stiff neck
- Vomiting
- Severe itching of body or scalp or scratching of scalp
- Unusual spots or rashes
- Unusual dark, tea colored urine – especially with a fever
- Ring worm, tinea corporis (contagious and non-contagious)
- Lice
- Diarrhea

If any of the above symptoms are present or if a child appears cranky or less active than usual, cries more than usual, or just seems generally sick at school or home, we ask that you not bring the child to camp that day.

PARENT AGREEMENT – INFECTION CONTROL POLICY

I have read and understand the infection control policy. I agree to abide by it for the protection of my child as well as the other children and staff members at Camp Sparks.

Parent Signature _____ Date _____

MEDICAL RELEASE FORM

PLEASE CHOOSE AND SIGN PART I OR PART II

PART I

The undersigned parent and/or guardian of: _____ do hereby consent to any and all medical and surgical treatments, including anesthesia and operation which may be deemed advisable by any qualified physician selected by agents or officials of the Hillsborough County Parks, Recreation and Conservation Department. The intention hereof is to grant authority to administer and to perform all and singularly any examination, treatments, anesthetics, operations, and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary by any qualified physician. **NO ACTION SHALL BE TAKEN UNTIL AN ATTEMPT IS MADE TO CONTACT ME AT THE PHONE NUMBER(S) LISTED BELOW.**

HOME: _____ BUSINESS: _____ CELL: _____

In witness of our consent and agreement to the matters stated above, we have subscribed our signature below:

Parent or Guardian Signature: X _____ Date: _____

Witness: _____ Date: _____

*Please sign below if you **DO NOT** wish to have your child treated in the case of an emergency.*

PART II

As parent or guardian of the minor listed below, **I do not desire to sign the medical and surgical release form above.**

Name of minor: _____

Parent/Guardian Signature: _____ Date: _____

After reading, understanding and completing the above application, I acknowledge, by my signature, the information contained in the above application is true and correct. I understand that falsification or misrepresentation of any information pertaining to the medical condition, behavior, or any other information contained in this application is grounds for immediate dismissal from the program.

Signature _____ Date _____

For Internal Use Only:

Accepted: Y___ N___ Camp Site: _____ Parent Notified?: Y___ N___

Date: _____

Lunch Letter? Y N Free Lunch? Reduced Lunch? Full Fee? Staff Initials

Program Fee Instructions

**The Summer Program will consist of 4 two-week sessions.
All camps will be open from June 18th through August 10th.**

Main registration will be at All People's on May 5th from 10 am- 2pm.

Payments will be accepted at the after school sites after that date if there is space available.

Fees:

\$38 per week: Full Price
\$30 per week: Reduced Lunch Rate (school lunch letter required)
\$20 per week: Free Lunch Rate (school lunch letter required)

Fees are payable in advance every two weeks. Payments must be received on or before—
June 15th, June 29th, July 13th, and July 27th.

This change was approved by the Board of County Commissioners and includes all recreation centers and summer programs managed by the Hillsborough County Parks, Recreation, and Conservation Department. Please make checks and money orders out to BOCC. A check acceptance form must accompany your application if you intend to write checks. VISA, Master Card, and American Express **will be accepted. Cash will not be accepted.**

Payments must be made prior to services rendered.

All Recreation Program Accounts for the after-school program must be current and paid in full before your child is accepted into the Camp Sparks Summer Program. In addition, those seeking a reduced rate must include a copy of the school lunch letter.