STUDENT INTAKE FORM

The purpose of this intake form is to understand the needs and goals of your child for our summer camp program. Please fill out this form to the best of your ability and return it to Summit Therapies.

Student Name: _____ Birth Date: _____

Guardian Name: _____

Contact Phone: _____ Contact Phone: _____

Contact Email: _____

Please indicate the weeks of camp you are interested in your child attending:

☐ June 1-5 ☐ June 8-12 ☐ June 15-19 ☐ June 22-26 ☐ June 3-July 29

☐ July 6-10 ☐ July 13-17 ☐ July 20-24 ☐ July 27-31 ☐ Aug 3-7

Camp times are 8:30-3:00 daily with extended care available for an hourly rate until 5:00pm.
Location of camp: 1936 Boothe Circle Longwood, FL

GOALS

What, if any, specific goals do you have for the student in summer camp?

☐ Academic: current goals and abilities, classroom placement and plans for next school year

_____

_____

_____

_____

☐ Social: socialization and interaction with others

_____

_____

☐ Physical: strength, endurance, balance, motor skill development (please specify below)

_____

_____

☐ Other (please specify below)

_____

_____

HISTORY

Has the student been involved in summer camps in the past?

☐ Yes ☐ No If yes, please describe:

_____

_____

Describe family composition (including siblings/ages, and others living in the home):

_____

_____

Please indicate your goals for summer camp (please also see teacher input form)

_____

_____

Indicate child's diagnoses, including age at diagnosis.

Diagnosis	Date of Diagnosis	Provider of Diagnosis

Please indicate if your child currently receives supportive therapies (e.g., Speech and Language, Occupational?). Please indicate arranged times.

Type of Therapy or Activity	Days and Times

STRENGTHS AND INTERESTS

What does the student do that makes you smile?

_____

_____

What makes the student smile?

_____

_____

What motivates the student (e.g., reward systems, positive encouragement, etc.)?

_____

_____

What are the student's least favorite activities?

_____

_____

AREAS OF SUPPORT

What makes the student angry or sad?

_____

_____

Are there situations, events, or types of stimuli that could trigger these feelings?

_____

_____

What does it look like when the student is angry or sad?

_____

_____

Is the student able to collect themselves afterward and return to a task?

_____

_____

What should we do when these feelings are triggered?

_____

_____

Are there additional things the student finds difficult or times when the student needs help (e.g., when transitioning from one activity to another)?

_____

_____

Communication Supports

What is the student's preferred method of communication or learning (e.g., words, pictures, gestures, etc.)?

_____

_____

How does the student ask for help?

_____

_____

How does the student interact with others in a social setting?

_____

_____

SUMMIT THERAPIES

Assistive Technology

Does the student use any communication devices?

_____

_____

Does the student use any mobility support?

_____

_____

Medical Needs

Indicate any medical conditions/serious illnesses (e.g., asthma, recurrent ear infections) experienced by your child.

- ☐ Allergies
- ☐ Sleep
- ☐ Educational
- ☐ Vision
- ☐ Feeding
- ☐ Other
- ☐ Hearing
- ☐ Sensory

_____

_____

Does your child require a special diet? If yes, please describe.

_____

_____

Does the student have any medical or physical restrictions or is the student on any medical action plans?

_____

_____

Are there any medical concerns we should be aware of?

_____

_____

Is the student continent? ☐ Yes ☐ No

Does the student have difficulty with any of the following (check all that apply)?

Physical

☐ Gait ☐ Range of motion ☐ Balance ☐ Coordination ☐ Strength ☐ Endurance

Vision

☐ No significant vision impairment ☐ Can see light/shadows ☐ Legally blind

Hearing

☐ No significant hearing impairment ☐ Mild loss ☐ Moderate/severe loss ☐ Deaf

Speech/Communication

☐ Verbal ☐ Nonverbal ☐ Sign Language

Hypersensitive to

☐ Touch ☐ Noise/Volume ☐ Unfamiliar environment ☐ Heat ☐ Cold

☐ Other: _____

Important Information

Please initial next to the following to acknowledge:

_____ Parents are to walk their child into Summit Therapies and sign their child in at the front office each day. Pick up is also done by parents signing their child out at the front desk.

_____ If a student is showing any signs of illness (for example: has a fever of 100.4 or higher, is vomiting, has diarrhea or seems out of sorts) please let staff as soon as possible and keep them home until they are symptom free

_____ If your child has a fever of 100.4 or higher, is vomiting, has diarrhea or seems overly lethargic they will be asked to be picked up asap.

_____ Each child needs to bring a backpack with a full change of clothes (clothes, socks, underwear and shoes), lunch box and communication folder

_____ Parents need to supply a water bottle, snack and lunch. Lunches may be refrigerated if needed but staff are not permitted to warm student's lunches. Filtered water is available for refilling if needed.

_____ If a child stays past the end of camp (3:00pm) for extended care, parents must provide a second snack

_____ Closed toe shoes are required at all times

_____ There is no nap time at Summit Summer Camp at this time

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

_____

Date

SCHOOL OR CHILDRCARE INFO

This section is to be completed by the child's current teacher or daycare provider. This information will provide us with information to continue to support your child academically, socially and with various executive functioning skills.

Educational Information	
School Name:	Teacher:
Grade:	Admin or Guidance Contact:
Type of Setting (daycare, self-contained, regular ed):	Teacher/Admin Phone:
Address:	Teacher Email:
Any behavior concerns relayed by the school:	

Academic

Reading: ☐ Above ☐ At grade level ☐ Below grade level

Summer goals that would best support this student are: _____

_____

Math: ☐ Above ☐ At grade level ☐ Below grade level

Summer goals that would best support this student are: _____

_____

Writing: ☐ Above ☐ At grade level ☐ Below grade level

Summer goals that would best support this student are: _____

_____

☐ Holds pencil age appropriately ☐ Uses scissors age appropriately ☐ Left-handed

Social

Summer goals that would best support this student are: _____

_____

Independent Functioning

Please check all that the student can reliably do independently daily

☐ Unpack my belongings ☐ Sit at small groups for 10 min ☐ Sit at circle time for 10 min

☐ Participate in circle time ☐ Engage in a center or activity for 5 min ☐ Gather supplies

☐ Transition to different areas with verbal prompts ☐ Clean-up activities (Preferred and non-preferred)

☐ Can follow group instructions ☐ Can work independently and alert teacher when help is needed or finished

☐ Can follow multiple step directions ☐ Engage in a center or activity for 10+ min

Summer goals that would best support this student are: _____

_____

_____

First Aid Release Form

Name of Client:

First Aid Release Form
I agree to allow personnel of Summit Therapies, LLC to administer simple first aide in the form of cleaning and bandaging a cut, burn, or scrape. I understand that Summit Therapies, LLC personnel are not authorized to administer medications and medical attention beyond simple bandaging. Any injury that occurs will be referred out to the nearest hospital and/or critical care facility or by dialing 911. Summit Therapies, LLC personnel are not authorized to transport injured recipients.

I agree to the terms as stipulated.

Signature of Client:

Date:

Signature of Caregiver/Guardian:

Date:

Signature of Summit Therapies Behavior Analysis Provider:

Date

Emergency Contact Form

Child's Full Name: _____

Nickname: _____ D.O.B: _____ Age: _____

Allergies: _____

_____

Medications: _____

_____

Other Medical Diagnosis:_____

_____

Emergency Contact

Name: _____ Phone: _____

Secondary Phone: _____ Relationship: _____

Name: _____ Phone: _____

Secondary Phone: _____ Relationship: _____

Financial Agreement

This financial agreement is to be signed and completed along with the Financial Contract which will be attached.

Terms of Payment (Step Up for Students)

- Summer camp funds must be input into the Step Up for Students portal prior to the week of camp beginning.

Terms of Payment (Private Pay)

- When week of camp is complete the provider, Summit Therapies, will approve the service in the portal.
- If a session is cancelled Summit Therapies will remove the invoice from the portal.
- Invoices are emailed weekly through QuickBooks.
- Payment must be received within 30 days from the date on the invoice.
- After that time, late payment fees of $30 per billing cycle will be assessed until payment is received in full.

Cancellation Policy

- Cancellations with 14 days' notice prior to the start of registered camp session will not be charged.
- Participants who do not attend their registered session (for any reason, including vacation, summer school, illness) or who do not contact Summit Therapies to cancel by the refund dates listed, will not receive a refund.
- Participants who do not attend their registered camp session due to any illness will not receive a refund for days or weeks missed.

Rates/Hours

- Please select which weeks you would like your child to attend Summit Summer Camp.
- Camp rates are $550 per camper per week
- Camp hours are Monday-Friday from 8:30am-3:00pm
- Extended care is available for private pay only (not Step-Up funds) from 3:00-5:00pm at an hourly rate of $35/hour.

☐ June 1-5 ☐ June 8-12 ☐ June 15-19 ☐ June 22-26 ☐ June 3-July 29

☐ July 6-10 ☐ July 13-17 ☐ July 20-24 ☐ July 27-31 ☐ Aug 3-7

I, _____ (client/ parent/ guardian), acknowledge that I have read the financial agreement of Summit Therapies, LLC. I accept full responsibility for prompt payment of all services rendered for _____ (client). I also assume financial responsibility for all attorney and collection agency fees in the event it becomes necessary to file suit to collect payment.

_____ Signature

_____ Date