A picture containing logo

Description automatically generated

**Connections Camp**

**2024 Application**

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| Name | Click or tap here to enter text. | Age as of 6/21/24 | Click or tap here to enter text. |
| Date of Birth | Click or tap here to enter text. | SSN | Click or tap here to enter text. |
| Parent/Guardian | Click or tap here to enter text. | Email Address | Click or tap here to enter text. |
| Address | Click or tap here to enter text. | Home/Cell Phone | Click or tap here to enter text. |
| City, State, Zip | Click or tap here to enter text. | Work Phone | Click or tap here to enter text. |

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| Emergency Contact Name (other than parent) | Click or tap here to enter text. | Phone Number | Click or tap here to enter text. |
| Relationship to Child | Click or tap here to enter text. | | |

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| MA/Access Number | Click or tap here to enter text. | Card Issue Number | Click or tap here to enter text. |
| Private Insurance Company | Click or tap here to enter text. | Name of Insured | Click or tap here to enter text. |
| Relationship to Child | Click or tap here to enter text. | Insured DOB | Click or tap here to enter text. |
| Individual ID | Click or tap here to enter text. | Group ID | Click or tap here to enter text. |

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| T-Shirt Size | Y-S  Y-M  Y-L  Y-XL  A-S  A-M  A-L  A-XL |

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| Does your child have any medical concerns? | No  Yes – Note: Click or tap here to enter text. |
| Does your child need to take medications during camp hours? | No  Yes – Med & Time:Click or tap here to enter text. |

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| Does your child have any behavior concerns (such as physical aggression or running away) that might compromise their safety of the safety of others? | No  Yes – Please Note: Click or tap here to enter text. |
| Child’s Current Behavioral Health Diagnosis | Click or tap here to enter text. |
| Does your child have a current evaluation? | No – BNI will contact you to schedule  Yes – Include a copy of the evaluation with the application |

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| Does your child receive any of the following services? | | | |
|  | No | Yes | Agency / Provider Name |
| IBHS |  |  | Click or tap here to enter text. |
| Blended Case Management |  |  | Click or tap here to enter text. |
| Family Based Mental Health |  |  | Click or tap here to enter text. |
| Outpatient Therapy |  |  | Click or tap here to enter text. |
| Psychiatry |  |  | Click or tap here to enter text. |

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| Please check if applies to your child | | | |
|  | Difficulty meeting and making friends |  | Trouble with anger management |
|  | Difficulty keeping friends |  | Difficulty initiating appropriate conversation |
|  | Difficulty being assertive |  | Difficulty maintaining appropriate conversation |
|  | Difficulty entering into a play situation |  | Difficulty switching topics in conversation |
|  | Difficulty in reciprocal play - leading play |  | Difficulty using and understanding humor |
|  | Difficulty in reciprocal play - letting a peer lead play |  | Difficulty using language socially in a flexible way |
|  | Difficulty with sportsmanship – winning and losing |  | Difficulty with picking up nonverbal social cues |
|  | Poor self esteem |  | Exhibits socially inappropriate behavior |
|  | Trouble with stress management |  | Difficulty understanding the needs of others |

|  |  |
| --- | --- |
| Will your child be attending before care? | No  Yes |
| If Yes, Select Days | Mon  Tues  Wed  Thur  Fri |
| Will your child be attending after care? | No  Yes |
| If Yes, Select Days | Mon  Tues  Wed  Thur  Fri |

|  |  |
| --- | --- |
| Will your child be absent from camp due to a planned absence or vacation? | No  Yes – Note Dates: Click or tap here to enter text. |