

**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 |

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| 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  |

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| 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. |