



Summer 2025

July 7th - July 31st

Monday - Thursday 8am - 2:30pm

**** Completing the application does not confirm a spot at camp. An email response of receipt will be sent and later a confirmation email will be sent if your child has been accepted to camp. Confirmation will be sent as soon as possible.**

Child's Name: _____ **Shirt Size:** _____

Date of birth: _____

Address: _____

Parents /guardians: _____

Home Phone: _____

Cell Phone: _____ (whose phone is this?) _____

Cell Phone: _____ (whose phone is this?) _____

Email address: _____

Preferred method of communication: _____

Emergency Contact: (Name) _____

Relationship to child: _____

Best and fastest method to contact: _____

Attendance:

Will your camper be attending full time (Mon-Thurs 8:30-2:30), Part time ?

If your camper will be visiting Camp Smiles on a Part Time schedule, please list the days/times they will be attending:

Location Preference (Select One)

- Seacoast Church (Conway)
- Palmetto Shores Church (Myrtle Beach)

Although Camp Smiles GS cannot guarantee your preferred location for Summer Camp, we will do our best to make all accommodations

Medical information: (provide a copy of your child's insurance card in case of emergency)

Primary Medical **Diagnosis:** _____

Is there a current condition or medical history of: (please describe)

Seizures: YES / NO ___ If yes, please describe type and onset:

Visual or hearing impairment: YES / NO If yes, please describe needs, strategies to assist with making sure Camp is enjoyable.

Does child wear **glasses, contacts, or hearing aids?** YES / NO

If yes, please indicate which: _____

Are there special instructions for their use? _____

Allergies: (bugs, latex, etc.) _____

Reaction: _____

Is an Epi-pen needed (If so, Parent to provide):

Active Infections or wounds: _____

Location: _____

Treatment and bandaging: _____

Medications: (dosage, time, and reason given; please be specific): Camp Smiles doesn't have a nurse on site.

Will your child need medication while attending Camp (8:30 am – 2:30 pm)? _____

If yes, please complete medication attachments for each medication to be given.

Being outside:

Do medications affect your child's ability to be outside in the heat during the day? _____

Does medication cause your child to burn easily or get sun poisoning easily? _____

Can your child wear sunscreen? _____

Diet:

Food allergies: _____

Reaction to food allergies: _____

Does this require emergency medication for exposure? (example: epi pen)

Specific Diet (liquid, soft etc.) _____

****If your child is on a specific diet, we ask that you provide lunch and snack for him/her, as well as provide instructions to effectively feed your child.***

Choking / swallowing risks: YES / NO

Please describe: _____

Does your child require any help or assistance with eating? YES / NO

Please describe _____

Are special utensils or plates required when eating? (You will need to provide) _____

Other medical issues we should be aware of: Please use another sheet if more space is needed:

Supervision: Please place an X by the level of supervision your child requires with any explanations (elopement or medical)

_____ Level 1: (Will stay with group with minimal supervision; no medical supervision needed)

_____ Level 2: (Will stay with group with supervision in close proximity; minimal medical supervision needed)

_____ Level 3: (Will wander from group, must have one on one supervision; requires supervision for medical concerns)

Personal Care Assistance:

Does your child require assistance with toileting? **YES / NO**

What kind? _____

Does your child wear a diaper that will need changing? **YES / NO**

Special instructions or issues: _____

Communication: Please place an **X** by the level of communication your child requires with any explanations.

_____ Level 1: Able to verbally communicate needs and hold conversations

_____ Level 2: Able to verbally communicate basic needs only but is sometimes difficult to understand.

_____ Level 3: Communicates through utterances and pointing

_____ Level 4: Uses sign language

_____ Level 5: Uses adaptive communication such as a communication board or book (parents will need to provide these if needed)

Please describe any communication needs:

Ambulatory:

Is your child in a wheelchair? **YES / NO**

Does your child need assistance in the form of canes, walkers, forearm crutches, etc.? **YES / NO**

Please tell us about any walking or positioning concerns/needs. _____

Behavior:

Please describe any behavior problems such as hitting, screaming, refusing directions, self-abuse, etc. and how you would like the camp staff to handle such behaviors. Please be very specific so we can ensure the safety and well-being of your child and other children. **Due to the mission of Camp Smiles GS to provide Summer Camp experience for individuals with medical and special needs that would not otherwise be able to attend a typical summer camp, we reserve the right to not accept campers who exhibit physically aggressive and verbally aggressive behaviors at any time. We also reserve the right to terminate attendance at Camp Smiles GS if such behaviors are exhibited.*

Personal information:

What time of day is your child at his/ her best? _____

Does your child need a nap mid-day? _____

Please tell us about napping habits _____

Please tell us things about your child that will help us make this a meaningful experience.

(Favorite TV show or movie, a favorite activity, things that are absolutely hated, etc.)

Special Interests: Please list any special interest (i.e. star wars, princesses, bubbles, etc.) your child has.

Music Therapy:

The Music therapy group leaders would like information about your child to make the music experience better for them.

What is your child's favorite music or song? _____

Has your child had previous music experiences (music therapy, band, chorus)? **YES / NO**

Sensory

Does your child have any sensory issues (tactile, sound, smells, etc.)? **YES / NO**

If yes, please describe:

Assistants/ ESY services:

PCA: Although not required you may provide your child with a personal helper or assistant. If you plan on providing assistance please give us information about this person and their role with your child. Include Name, contact information, times available, and assistance being provided to your child. _____

If **ESY** services (provided by child's school district personnel) need to be scheduled during camp dates and times, please let us know the schedule so we can make sure that your child is included in camp activities prior to or after; also please indicate the service and service providers name so we are aware of who will be working with your child.

Payment:

Your assistance with fundraising efforts is vital to maintaining a cost free camp. In what way(s) are you able to participate in our fundraising efforts? Please check at least one.

- Fundraising
- Soliciting Sponsors/Donors
- Assisting with Community Events

Does your child receive a DDSN waiver in the summer? **YES** / **NO**

Would you be willing to apply this money to the camp? **YES** / **NO**

Notes:

Please use the space below for any comments or concerns about any of the above sections.

**** Camp Smiles GS is not a therapeutic camp. We are a summer day camp. We strive to create memories for our campers by meeting them at their interest levels and needs. We are structured so that we can provide experiences for all of our campers; we use strategies and materials that we are familiar with; however, we make accommodations to ensure that our campers are enjoying their summer☺ We encourage parent/family input. We want to make our campers SMILE!**