Child's Name _____

Camp Prov 2026 Camper Registration Form

➔ (**EACH child must have a separate form**) ➔
- Please Write Neatly! –

The full tuition of Camp Prov is $130, which is a small percentage of the actual cost. Due to needing to restrict numbers of campers we will need to limit the ages of Campers this year. We will be accepting children ages 2-13.

Child's Name **First** **Last**	Date of Birth:	Age on 7/1/26:

Name Child Goes By:	Siblings at Camp (First Last):

Child's Diagnosis:	Primary Language:

Street Address:	City, Zip Code:

Parent/Legal Guardian (First Last):	Relationship:

Primary Phone Number:	Email:

Please indicate which week & session you prefer by numbering your choices 1-4
Sessions are filled on a first come, first served basis. (#1 for first choice to #4 fourth choice by preference)

July 6-10:	9am-12pm ☐	1pm-4pm ☐
July 13-17:	9am-12pm ☐	1pm-4pm ☐
July 20-24:	9am-12pm ☐	1pm-4pm ☐
July 27-31:	9am-12pm ☐	1pm-4pm ☐
August 3-7:	9am-12pm ☐	1pm-4pm ☐

Child's T-shirt size: ☐X-Small ☐ Small ☐ ☐ Med. ☐ Large ☐ X-Large ☐
Adult size if needed (please specify size): _____

Providence Children's Center Camp Prov
900 Pacific Ave Suite 130, Everett WA 98201
Phone: 425.258.7311 ext. 0 | FAX 425.258.7618 | Camp.Prov@providence.org

Child's Name _____

***Please Note*: We are here to support your child the best way we can during their time at Camp Prov!**

Tell us about your child
What are his or her strengths and abilities?

What makes him or her a great kid?

What makes your child feel proud of themself?

What are the goals you have for your child? (ex. Make new friends, just have fun, etc.)

Current Services
Does your child receive services at Providence Children's Center?
Yes☐ No☐

Hearing & Vision
How does your child hear and see?
☐ Typical Hearing ☐ Hearing Loss
☐ Wears hearing aid/s ☐ Cochlear Implant
☐ Other _____
☐ Vision loss ☐ Wears glasses ☐ Uses a cane
☐ Other_____

Communication (are there specific signs/gestures that your child uses to communicate? We also encourage you to discuss these further with your child's buddy.

How does your child communicate?
Spoken Words: understandable to others? Yes☐ No☐
Sounds☐ Signs☐ Gestures☐ Communication Board, PECS☐
☐ Spoken words -- understandable to others? ☐ Yes☐ ☐ No☐
☐ Sounds☐ ☐ Signs☐ ☐ Gestures☐ ☐ Communication board, PECS☐
Augmentative Communication device☐ Sign Language☐
☐ Other: _____

Child's Name _____

If your child has a communication device, please plan on bringing it labeled with their name to camp and allow time on the first day to review with staff.

How will your child tell us he/she is:
Having a good time _____

Is sick or in pain _____

Anything else we should know about your child's **Communication**? _____

_____

Swimming- NOTE: The swimming pool is closed.
It is OK for my child to get wet in the waterpark: Yes☐ No☐

It is OK for my child to use Camp Provided Sunscreen at Camp ☐
Yes☐ No☐

Likes and Dislikes
My child tends **to enjoy** the following:
☐ Brushing ☐ Squeezing ☐ Jumping ☐ Swinging ☐ ☐Spinning ☐
☐ Other: _____

What toys does your child enjoy:
☐ Toy cars ☐ Musical instruments ☐
☐ Play food / Kitchen ☐ Balls ☐ Art ☐ ☐ Reading ☐
☐ Other: _____

My child tends to **avoid** the following:
Loud noises ☐ Friend / peer interaction ☐ Animals ☐
Large Group ☐ Food ☐ Certain Smells (what)_____
☐ Other: _____

Behavior
Does your child have a behavior plan? (if yes, please attach it or a summary so we can follow it also)
Yes☐ No☐

What should we know about your child's behavior? (such as going from one activity to another)

What do you do to calm and reassure your child?

*If your child has a comfort toy/object, please send it **labeled** with name in the child's backpack in the event we need it to help soothe.*

_____

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Child's Name _____

_____

_____

Does your child: (check all that apply)
Runs away☐ Hits☐ Kicks☐ Spits☐
Bites/Scratches/Pinches/Hits themselves☐ Bites/scratches/pinches others☐
Wanders away☐

Runs away☐ Hit☐ Kick☐ Spit ☐
☐ Bite/scratch/pinch / hit themselves☐ ☐ Bite/scratch/pinch others☐
☐ Wanders away☐
☐ Other: _____

For all that apply: What are causes for these behaviors? When they occur, what strategies do you typically use to help your child?

_____

If you child is in distress. What are some typical causes? What strategies do you tend to use to relieve this stress? _____

Social and Home

What does your child typically enjoy doing:
playing with a friend ☐ ☐playing with several friends☐ playing by themselves ☐
☐ reading ☐ ☐ drawing / painting / crafts☐ ☐ building (like Legos)☐
☐ team sports (soccer, football)☐ individual sports☐
☐ prefers to be outdoors☐ prefers to be indoors☐ ☐ music☐
☐ Other_____

_____

When separating, what works for you and your child?
☐ needs some encouragement but otherwise separates well☐
☐ some crying, needs reassurance, sometimes distraction☐
☐ My child has never been separated from me or family☐
☐ Other_____

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Child's Name _____

Mobility

How does your child move around?

- ☐ Walks
- ☐ Crawls
- ☐ Uses walker, crutches or cane(s)
- ☐ Uses Wheelchair ☐ Other: _____

Anything else we should know about your child's **mobility**?

Toileting

My child:

- ☐ Needs no help or reminders to go to the bathroom
- ☐ Wears a diaper
- ☐ Needs prompting to go to bathroom
  - How often: _____
  - What do you say to prompt: _____

How I know my child needs to use the bathroom: _____

Help my child needs when toileting

- ☐ None
- ☐ Clothing management
- ☐ Wiping / hygiene

Comfort/Security

We call parents when there is a serious medical issue. Are there any other reasons you would want us to call you?
(examples: Inconsolable or crying for a long period of time)

_____
_____

Emergency Contacts

1) Name: _____ Phone _____

2) Name: _____ Phone _____

For safety reasons, you or your designated caretaker may be required to provide a password upon picking your child up from Camp.

Providence Children's Center Camp Prov
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Child's Name _____

***Your family's password will be*:** _____

Child's Health History

Current height: _____ Weight: _____

Check if your child has any of the following conditions:
Infections☐
Diabetes☐
Seizures/Convulsions (see below)☐
Stomach or intestinal issues☐
Urinary/Kidney difficulties☐
Asthma, Bronchiolitis☐
Allergies (other than to drugs)☐
Respiratory/Breathing Problems☐
High/Low Blood Pressure☐
☐ Sensitivities to: ☐ sun☐ ☐ sunscreens☐
If you checked any of the above, please give details: _____

_____

Dietary

Does your child have any of these feeding or dietary concerns? (note: Camp Prov is nut-free and gluten free for our campers!)

☐ Gluten free☐ ☐ Casein free☐
☐ feeding tube☐ ☐ Diabetes☐ ☐ Swallowing/choking☐
☐ Nut allergy☐ ☐ Lactose intolerance☐ ☐ Other food allergy☐

_____

Medical Information

Does your child take medications? ☐ Yes☐ ☐ No☐

If yes*, please list:

Name:	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Please Note*: Camp staff will *NOT* be able to administer medications except in life-threatening emergency. We are also unable to provide suctioning and/or providing tube feeding.**

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Child's Name _____

List any medication allergies and their reactions

_____

_____

Any significant allergies that require EpiPen (or similar) left with RN while at camp

☐ Yes ☐ No

Seizure Information

If your child has seizures, please explain:

Frequency: _____ Length: _____

Date of most recent seizure: _____

Triggers: _____

What do the seizures look like (head bobbing, eyes roll back, blank stare, etc.)?

_____

What is the plan of care if your child has a seizure while at Camp (Our typical response would be to call 911 immediately)

_____

I will leave my child's emergency medications with RN all week

☐ Yes ☐ No

Any other medical issues information you would like to report? (e.g. overheating easily, recent hospitalization, surgery, medical equipment etc.)

_____

_____

Please Note: *We cannot be responsible for any lost items at Camp. We highly recommend labeling all items brought to Camp with permanent pen.*

Checklist: Please sign and return

- ☐ **This application**
- ☐ **Copy of your child's official immunization records (or declination of immunization)**
- ☐ **Signed (attached) photo release (optional)**
- ☐ **Provide payment per Payment Options (next page)**

Send all **of the above to:**

Providence Children's Center Camp Prov

900 Pacific Ave Suite 130, Everett WA 98201

Child's Name _____

-or-
FAXED to 425.258.7618

Due to the insecure nature of email, we would prefer you did not email forms to us.

Release/Permission

I verify that the above medical/health information on my child is complete and accurate. I also understand that all reasonable measures will be taken to safeguard the health and safety of all participants and I will be notified as soon as possible in case of emergency affecting my child. If I cannot be reached in an emergency, I hereby authorize you and a physician to render all services and treatment deemed necessary at my expense.

Parent / Guardian Signature: _____

Date: _____

Continued next page

Payment Options (please check)

Child's Name _____

☐ $130 for the full tuition

☐ ☐ My Child is DDA respite eligible, and am planning on using my child's hours for Camp Prov.

My Child's DDA number ☐☐☐☐☐☐☐☐☐WA

My Child's DDA Caseworkers Name_____

My Child's Caseworker's phone_____

My Child's Caseworker's email_____

DDA office location_____

☐ ☐ If you are interested in **financial aid** please check here and we will contact you.
No payment due at this time.

☐ I would like information on sponsoring a child in need for Camp Prov

Payment enclosed ☐ Check

☐ Visa ☐ ☐Mastercard ☐ ☐ AMEX ☐ ☐ Discover ☐

Amount__$_____

Name on card _____

Number_____ EXP date_____

Zip Code associated with card_____

C.V.V. number_____

Signature authorizing credit / debit card
_____

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Child's Name _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS

1AUTH

DO NOT WRITE OUTSIDE BORDER AREA

1. I authorize Providence Health & Services to 1) interview, 2) photograph, and/or 3) videotape me and to use the interview(s), photograph(s), or videotape(s) in connection with marketing, public relations and other news media purposes which include but may not be limited to electronic or print media, brochures and other printed materials, displays, and/or radio and television. If the intended use is not included above, please indicate:

   Other Use: _____

   Name: (please print) _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Daytime Phone: _____

2. I understand that I have the right to request cessation of recording or filming, or interviewing.
3. I understand that the information used or disclosed pursuant to this authorization is not covered by federal privacy regulations, and that any health information disclosed may be re-disclosed and is no longer protected under federal law.
4. I understand that this authorization is for the uses listed above. The use of these materials for archival or historical purposes is part of PH&S operations and is not encompassed in this authorization.
5. I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
6. This authorization only applies to information created within 90 days from the date of this authorization. I understand that Providence Health & Services may use this information at any time up to five years from the date signed, or upon revocation, whichever occurs first. PH&S will honor my revocation to the extent this authorization has not been relied on for the creation and distribution of materials that include my information. To revoke this authorization, I must send a written statement, including my full name, address and phone number stating that I am revoking this authorization to:

   Marketing and Communications
   Providence Regional Medical Center Everett
   PO Box 1147, Everett WA 98206

7. I have read this authorization and I understand it, and affirm that I have reached the age of legal majority (18) according to the laws of Washington State. By:

   _____ Date: _____
   INDIVIDUAL/PERSONAL REPRESENTATIVE

   Personal Representative's Name (please print): _____

   Description of personal representative's authority: _____

   _____

For official Providence use only.

Name and title of PH&S employee arranging authorization: _____

Description of interview, photograph and/or videotape: _____

WHITE COPY: MEDICAL RECORD YELLOW COPY: MARKETING AND COMMUNICATION PINK COPY: PATIENT

PROVIDENCE Regional Medical Center Everett

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children
900 Pacific Ave. • Everett, WA 98206

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS (08/09)

#31591 (09/21/09) - D

Align Patient Sticker Here

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