



## 2021-2022 PARTICIPANT APPLICATION

PARTICIPANT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

NICKNAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GENDER: \_\_\_\_\_

ETHNICITY:  WHITE  HISPANIC  ASIAN  EAST ASIAN  PACIFIC ISLANDER  AFRICAN-AMERICAN  
 NATIVE AMERICAN  OTHER \_\_\_\_\_

PARTICIPANT'S HOME ADDRESS: STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ COUNTY \_\_\_\_\_

LEGAL GUARDIAN (PRIMARY EMERGENCY CONTACT): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ GUARDIAN'S PLACE OF EMPLOYMENT: \_\_\_\_\_

GUARDIAN'S ADDRESS (if different from Participant): STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (CELL) \_\_\_\_\_ PHONE (HOME) \_\_\_\_\_

PHONE (WORK) \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMERGENCY CONTACT (OTHER THAN GUARDIAN): NAME \_\_\_\_\_

RELATIONSHIP TO PARTICIPANT \_\_\_\_\_ PHONE (CELL) \_\_\_\_\_

PHONE (HOME) \_\_\_\_\_ E-MAIL \_\_\_\_\_

HOW MANY YEARS HAS THE PARTICIPANT ATTENDED OUR PROGRAM? \_\_\_\_\_

HAVE THEY ATTENDED ANOTHER PROGRAM? \_\_\_\_\_

PLEASE LIST PROGRAM(S) AND DATES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARTICIPANTS ARE ASSIGNED TO SESSIONS BY VIA'S ADMINISTRATIVE STAFF BASED ON AN ASSESSMENT. WE WILL MAKE EVERY EFFORT TO PLACE A PARTICIPANT IN THE SESSION(S) OF YOUR CHOICE. COMPLETED APPLICATIONS ARE PROCESSED AS THEY ARE RECEIVED ON A FIRST-COME, FIRST-SERVED BASIS.**

PLEASE CHECK ALL THE FOLLOWING THAT APPLY TO THE PARTICIPANT AND PROVIDE DETAILED INFORMATION. USE ANOTHER SHEET OF PAPER IF NECESSARY. ANSWERS TO THESE QUESTIONS WILL GREATLY AID COUNSELORS IN PROVIDING CARE TO YOUR PARTICIPANT.

### PARTICIPANTCARE INFORMATION

PLEASE LIST ANY NECESSARY ITEMS PARTICIPANT WILL BE BRINING TO CAMP, SUCH AS GLASSES, CONTACT LENSES, HEARING AIDS, ORTHOTICS, ETC.

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PARTICIPANT'S HEIGHT: \_\_\_\_\_ PARTICIPANT'S WEIGHT: \_\_\_\_\_

### SLEEPING

GETS UP DURING THE NIGHT (PLEASE EXPLAIN: I.E.: GOES TO THE BATHROOM, SLEEP WALKS, WANDERS, ETC.)

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HAS A SPECIAL NIGHT-TIME ROUTINE (PLEASE EXPLAIN) \_\_\_\_\_

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DOES PARTICIPANT NEED BED RAILS OR OTHER SPECIAL NIGHT CARE?  YES  NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

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### EATING AND DRINKING

HAS A SPECIFIC DIET/NUTRITION NEED OR RESTRICTIONS (PLEASE EXPLAIN) \_\_\_\_\_

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HAS ANY FOOD ALLERGIES (PLEASE EXPLAIN) \_\_\_\_\_

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DIABETIC:  YES  NO IF YES,  TYPE 1 DIABETES  TYPE 2 DIABETES

### WASHING/BATHING

INDEPENDENT  NEEDS PARTIAL ASSISTANCE  NEEDS TOTAL ASSISTANCE

HAS SPECIAL BATHING NEEDS (PLEASE EXPLAIN) \_\_\_\_\_

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HYGIENE, SUCH AS BRUSHING HAIR OR TEETH:  INDEPENDENT  NEEDS PARTIAL ASSISTANCE  NEEDS VERBAL REMINDERS/PROMPTING (IF ASSISTANCE IS NEEDED, PLEASE EXPLAIN) \_\_\_\_\_

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**DRESSING**

INDEPENDENT     NEEDS PARTIAL ASSISTANCE     NEEDS VERBAL REMINDERS/PROMPTING

IF ASSISTANCE IS NEEDED, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

**TOILETING**

INDEPENDENT     NEEDS VERBAL REMINDERS/PROMPTING

IF ASSISTANCE IS NEEDED, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

HAS SPECIAL TOILETING NEEDS (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

STRUGGLES WITH CONSTIPATION (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

**SOCIALIZATION/BEHAVIORS**

HAS A FRIEND WHO IS ATTENDING?     YES     NO

IF THE PARTICIPANT HAS A FRIEND THEY WOULD LIKE TO SHARE A LODGE WITH, PLEASE LIST THE FRIEND'S NAME HERE: \_\_\_\_\_

(WE WILL TRY TO ACCOMMODATE YOUR REQUEST, BUT MAY NOT BE ABLE TO IN ALL CASES)

BEEN SEPARATED FROM THE FAMILY BEFORE?     YES     NO

IF YES, HOW WAS THEIR EXPERIENCE? \_\_\_\_\_  
\_\_\_\_\_

DOES PARTICIPANT HAVE ANY BEHAVIOR MANAGEMENT PLAN THAT IS USED AT HOME OR SCHOOL?

IF YES, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

WHAT ARE SPECIFIC ACTIVITIES THAT HELP SOOTHE OR CALM PARTICIPANT? (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

HOW DOES PARTICIPANT COPE WITH STRESS? (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

THE DINING HALL CAN BE A LOUD LOUD/NOISY SPACE; HOW WILL PARTICIPANT HANDLE THIS SETTING? (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

DOES PARTICIPANT HAVE ANY HISTORY OF HARM TO SELF OR OTHERS? IF SO, PLEASE GIVE A DATE AND DESCRIBE DETAILS OF LAST INCIDENT: \_\_\_\_\_

DOES THE PARTICIPANT HAVE A HISTORY OF INAPPROPRIATE SEXUAL BEHAVIORS? PLEASE EXPLAIN: \_\_\_\_\_

HAS ANY SPECIFIC FEARS? PLEASE EXPLAIN: \_\_\_\_\_

ACTIVITY RESTRICTIONS (I.E.: SWIMMING, CAMPOUTS, COOKOUTS, FIELD TRIPS, HIKES, ETC.): \_\_\_\_\_

### SWIMMING

PLEASE NOTE: LIFEGUARDS ARE ON DUTY AT EACH SIWM PERIOD AND COUNSELORS PROVIDE IN-WATER ASSISTANCE.

- SWIMS       NEEDS FULL-TIME HELP IN WATER       NEEDS LIFE JACKET SOMETIMES  
 ENJOYS WATER       DOES NOT LIKE WATER       REQUIRES LIFE JACKET

COMMENTS: \_\_\_\_\_

### SEIZURES / OTHER HEALTH

HAVE A HISTORY OF SEIZURES?  YES       NO      TYPE: \_\_\_\_\_

FREQUENCY \_\_\_\_\_      DURATION \_\_\_\_\_

APPEARANCE \_\_\_\_\_      TRIGGERS \_\_\_\_\_

LAST SEIZURE (IF INFREQUENT) \_\_\_\_\_      POST SEIZURE/RECOVERY \_\_\_\_\_

INSTRUCTIONS FOR HANDLING SEIZURES \_\_\_\_\_

LIST ANY SPECIAL EMERGENCY CARE FOR SEIZURES \_\_\_\_\_

ADDITIONAL COMMENTS \_\_\_\_\_

HAVE A CARDIAC CONDITION?  YES       NO

IF YES, LIST CARE AND LIMITATIONS: \_\_\_\_\_

HAVE ANY SEVERE RESPIRATORY PROBLEMS?  YES       NO

IF YES, LIST CARE AND LIMITATIONS: \_\_\_\_\_

HAVE ANY ALLERGIES?  YES       NO

IF YES, LIST CARE AND LIMITATIONS: \_\_\_\_\_

**OTHER INFORMATION**

WHAT ARE PARTICIPANT'S INTERESTS AND HOBBIES? \_\_\_\_\_

DOES THE PARTICIPANT WANT TO COME TO THE PROGRAM?  YES  NO

PLEASE EXPLAIN: \_\_\_\_\_

WHAT DO YOU WANT THE PARTICIPANT TO GAIN FROM THEIR STAY? \_\_\_\_\_

INDICATE ANY RECENT SURGERIES OR SERIOUS INJURIES \_\_\_\_\_

HAVE THERE BEEN ANY RECENT CHANGES IN THE PARTICIPANT'S ENVIRONMENT/FAMILY? \_\_\_\_\_

WILL PARENTS POSSIBLY BE ON VACATION DURING SESSION?  YES  NO

DOES PARTICIPANT KNOW?  YES  NO

IF YES, PLEASE GIVE COMPLETE DETAILED CONTACT INFORMATION \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF YOUR HEALTH INSURANCE COMPANY \_\_\_\_\_

CERTIFICATE NUMBER \_\_\_\_\_ MEDI-CAL NUMBER \_\_\_\_\_

**\*A COPY OF INSURANCE CARD SHOULD ACCOMPANY APPLICATION\***

**PARTICIPANT ACCEPTANCE CONDITIONS**

VIA SERVICES, INC. RESERVES THE RIGHT TO REFUSE SERVICES TO ANY INDIVIDUAL WHEN THE CAMP STAFF DETERMINES THAT ADEQUATE SUPPORT CANNOT BE PROVIDED TO THE INDIVIDUAL. THESE DECISIONS ARE MADE ON AN INDIVIDUAL BASIS, BY THE PROGRAM DIRECTOR OR DESIGNEE.

PARENTS, CARE PROVIDERS, REGIONAL CENTERS (FOR PEOPLE USING REGIONAL CENTER FUNDING) OR OTHER APPROPRIATE AGENCIES WILL BE NOTIFIED IN THE EVENT OF ANY SERIOUS INJURY OR ILLNESS REQUIRING MORE THAN BASIC FIRST AID, OR IN THE CASE OF ANY SIGNIFICANT INCIDENT OR BEHAVIOR PROBLEM.

**PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN YOUR NAME BELOW**

I AGREE TO THE PARTICIPANT ACCEPTANCE CONDITIONS ABOVE. SHOULD IT BECOME NECESSARY FOR MY PARTICIPANT TO LEAVE VIA WEST CAMPUS, OR ANY VIA SERVICES, INC. FUNCTION, FOR ANY REASON, I WILL MAKE PROVISIONS TO BRING THE PARTICIPANT HOME. I HEARBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL PERTINENT INFORMATION, INCLUDING MEDICAL INFORMATION, REGARDING THIS PARTICIPANT TO VIA SERVICES, INC. I AGREE TO NOTIFY VIA SERVICES, INC. IN ADVANCE OF PARTICIPANT'S SESSION OF ANY CHANGES THAT NEED TO BE MADE IN THIS APPLICATION.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**RELATIONSHIP TO PARTICIPANT:** \_\_\_\_\_