A Spark of Possibilities

Admission Packet

A Spark of Possibilities is a brand new sensory and unlicensed day camp center located in Elk River, Minnesota. We provide a variety of services to meet the needs of many. A Spark of Possibilities is working towards their American Camp Association Accreditation and 245D License through the Minnesota Department of Human Services. We are excited to offer a variety of services including day camps, before and after school supports, special events, and parent's night out. Coming after we get licensed by DHS and ACA we will be able to also provide specialized services and respite care.

Step 1: Complete the entire Registration Packet

Step 2: Submit all required forms
☐Annual Physical
☐Medication List from Healthcare Provider, or Home Care agency
☐Registration Packet
Please remember spots are saved in the order they are received, with completed deposit

Step 3: Complete an intake with one of our intake specialists/ team, this can be done over the phone, in person or video. This intake will go more in depth about the participant, their medical needs and plan of care.

Step 4: Watch your mailbox/ email for confirmation and a welcome packet from A Spark of Possibilities. This will include the session(s) for which the participant has been registered or waitlisted. It will also go into details about drop-off/pick-up procedures, if any balance is due and any other important information.

Step 5: FIRST DAY AT A SPARK OF POSSIBILITES

555 Railroad Drive Ste D
Elk River, Minnesota 55330
info@spark2hope.org
763-260-0182

Personal Information

Participant Name: _____ Nick Name: _____
Legal First Name *Last* *Middle Initial*

Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*
County of Residence: _____
Telephone: (____) _____ Email: _____
Age: _____ Date of Birth: _____Male /Female _____ Height: _____Current Weight: _____
Religious Preference we need to be aware of: _____
Race:

☐White ☐African American ☐First Nation ☐Asian
☐Hispanic ☐Multi Racial ☐Other

How did you find out about A Spark of Possibilities?

☐Advertisements ☐Word of Mouth/Friends ☐Web Search ☐School
☐ Social Worker/Case Manager ☐A Website (please list) or other way: _____
Attend school: ☐ Yes ☐No
If yes, where: _____
Is the Participant employed? ☐ Yes ☐No
If yes, type of work? _____
If attending camp sessions, has the participant ever been to any other camp before? ☐ Yes ☐No
If yes, Camp Name(s) & when _____

Supervision

Supervision/ Support needed: ☐High (1:1) ☐ Medium (1:3) ☐ Low (1:5)

Contact Information

Primary Contact #1 **This is where all mail correspondence will be sent**

☐Parent ☐Guardian ☐Other, please specify _____
Name: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____

Primary Contact #2

☐Parent ☐Guardian ☐Other, please specify _____
Name: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____

Emergency Contact #1 **first point of contact**

Name: _____ Relationship to Participant: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____)_____ Email: _____
Employer: _____Work Phone Number: (____)_____
Does this individual have permission to pick up and transport the participant in the event contact #1 or #2 cannot be reached?
☐Yes ☐No

Emergency Contact #2 **second point of contact**
Name: _____ Relationship to Participant: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____) _____ Email: _____
Employer: _____Work Phone Number: (____) _____
Does this individual have permission to pick up and transport the participant in the event contact #1 or #2 cannot be reached?
☐Yes ☐No

Additional Authorized Pick-Up Person
Name: _____ Relationship to Participant: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____) _____ Email: _____
Employer: _____Work Phone Number: (____) _____

Additional Authorized Pick-Up Person
Name: _____ Relationship to Participant: _____
Address: _____
Steet (include Apt. #, if applicable) *City* *State* *Zip*

Phone Number: (____) _____ Email: _____
Employer: _____Work Phone Number: (____) _____

Social Worker/Case Manager
Name: _____ Agency: _____
County: _____ Email: _____
Office Phone Number: (_____) _____ Cell Phone Number: (_____) _____

All correspondence regarding the registration of this application will be sent to primary contact #1 and any other individuals chosen below:
☐Primary Contact #2 ☐Emergency Contact #1 ☐ Emergency Contact #2
☐ Social Worker/Case Manager ☐Other, please specify _____

Health Information

Primary Doctor
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
Street Number *City/State/Zip*

Mental Health Provider
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
Street Number *City/State/Zip*

Dental Provider
Name: _____ Clinic: _____
Address: _____ Phone Number: (____) _____
Street Number *City/State/Zip*

Has the participant been hospitalized within the last 12 months? ☐Yes ☐No
If yes, please explain _____
_____
Has the participant been treated in an Emergency Room within the last 12 months? ☐Yes ☐No
If yes, please explain _____
_____

Please list any operations, serious injuries, or recurring illnesses: _____
_____

Diagnosis/Disability/Condition
REQUIRED Primary Diagnosis (medical, no abbreviations): _____
Secondary Diagnosis: _____

Please indicate any additional diagnosis/disabilities/conditions that apply

Neurodevelopmental

☐Angelman Syndrome
☐Autism Spectrum Disorders
☐Cerebral Palsy
☐Down Syndrome
☐Global Developmental Delays
☐Fetal Alcohol Spectrum
☐Sensory Processing Disorder
☐Prader-Willi Syndrome
☐Rett Syndrome
☐Williams Syndrome
☐ADHD
☐ Inattentive
☐ Hyperactive
☐ Combine Type
☐Intellectual disabilities
☐ Mild
☐ Moderate
☐ Severe
☐ Profound

☐Other: _____

Neurological **Protocols needed on file*

☐Anxiety
☐Bipolar
☐Borderline Personality Disorder
☐Depression
☐Dissociative Disorders
☐Eating Disorders
☐*Epilepsy/ Seizure Disorders
☐Neurobehavioral Disorder associated with Prenatal Alcohol Exposure
☐Obsessive Compulsive Disorder
☐Oppositional Defiant Disorder
☐Post-Traumatic Stress Disorder
☐Reactive Attachment Disorder
☐Traumatic Brain Injury
☐Tourette Syndrome
☐Other: _____

Pulmonary (Lung) **Protocols needed on file*

☐Asthma
☐Aspiration pneumonia – history
☐Congenital lung issues
☐Cystic Fibrosis
☐Respiratory Failure – history
☐*Tracheostomy
☐Other: _____

Cardiac (Heart/ Blood)

☐Sickle Cell Anemia
☐Anemia
☐Bleeding Disorders -If yes, describe: _____
☐Heart Disorders- If yes, describe: _____
☐Other: _____

Muscular & Neuromuscular **Protocols needed on file*

☐Amputee
☐Muscular Dystrophy
☐*Mobility equipment
☐*Orthopedic appliances
☐Paraplegic
☐Quadriplegic
☐Spasticity
☐Spasms
☐Spina Bifida
☐Other: _____

Sensory & Communication

Vision impairment

☐Blind
☐Vision impairment- If yes, please explain_____
☐Wears glasses
_____
☐ Yes
☐ No

Hearing impairment

☐Deaf
☐Hearing impaired
☐Has hearing device
☐ Yes: explain _____
☐ No

Communication impairment

☐Expressive communication ☐Receptive communication ☐Limited functional communication
☐No functional communication ☐Communication Augmentations/ Alternatives
Notes: _____

Oral sensory

☐Oral sensory input needs- If yes, explain: _____
☐Oral aversion
☐PICA

***Specialized Care Needs** **Protocols needed on file*

☐*Catheter
- ☐ Indwelling
- ☐ In and out on a schedule
- ☐ Suprapubic

☐*Dysautonomia
- ☐ Temperature
- ☐ Respiration
- ☐ Heart Rate
- ☐ Blood Pressure

☐*Diabetes
- ☐ Type 1
- ☐ Type 2

☐*Colostomy

☐*Feeding Tube ☐*Other: _____

Allergies

☐Food: _____
☐Plants: _____
☐Insects: _____
☐Medicines: _____
☐Environment: _____
☐Animals: _____
☐Other:_____
Reaction type:
☐Anaphylaxis ☐Rash/Hives ☐Upset Stomach
☐Other: _____

Seizures

Does the participant have a seizures/seizure disorder? ☐Yes ☐No
Type of Seizures:
- ☐ Grand Mal
- ☐ Absence (loss of consciousness)
- ☐ Myoclonic/Clonic (jerking)
- ☐ Tonic (muscle stiffness//rigidity)
- ☐ Atonic (loss of muscle tone)
- ☐ Other, describe: _____

Frequency of seizures: _____
Duration of seizures: _____
Date of last seizure: _____
Are seizures controlled with medication? ☐Yes ☐No
When to notify emergency contact?
☐Every time
☐Over 5 Minutes
☐Other _____

Please describe what the participants seizures looks like (including behavior before, during and after event):
_____
_____
_____

Immunizations

Does the participant have all of the recommended vaccines for their age? ☐Yes ☐No
If no, please explain and attach your medical or religious exemption with the registration:
_____
If yes, please include a record with your registration that shows month/year of all immunizations that are recommended for the participant's age. A physician's statement, a government immunization report or a school immunization report can also be accepted. The report MUST show the month/year of last tetanus shot.

Insurance Information

Medical Assistance #: _____ Primary Insurance Provider Name: _____
Policy #: _____ Policy Holder's Name: _____

Behaviors

Behaviors

Does the participant display any behavioral issues? ☐ Yes ☐ No

If yes, please check all behaviors below:

☐Self-Injury ☐Spitting ☐Biting
☐Property Destruction ☐Elopement ☐Yelling
☐Inappropriate Language ☐Not Following Directions ☐Sexual Acting Out
☐Physical Aggression: (kicking/hitting/punching)
☐Other: _____

If any behaviors above are checked, please describe when these behaviors typically occur, what they look like, how long they last:

_____
_____
_____
_____
_____

Please describe any behavior triggers:

_____
_____
_____

When do you see most behaviors occurring?

☐Hungry ☐Uncomfortable ☐Hurt
☐Bored ☐Dysregulated ☐Unknown
☐Other: _____

How often do these behaviors occur?

☐Seldom (1x/month) ☐ Often (1x/week) ☐Frequently (More than 1x/week) ☐Daily

What behavioral indicators might exist that show the person is in distress before a behavior exists?

_____
_____

Please explain what the behavior typically looks like, what redirection is done, and what the typical response is to redirection:

_____
_____

What are effective tools for de-escalation of the behavior?:

_____
_____
_____

Functioning and Communication

Communication & Social Skills

Can the participant communicate wants and needs effectively to others? ☐Yes ☐No

How does the participant communicate? Please check all that apply

☐Verbally ☐ Sign Language ☐Electronic Device
☐Gestures ☐Other _____

Can the participant understand/respond to questions? ☐Yes ☐No

Does the participant have difficulty understanding the communication of others? ☐Yes ☐No

Is the participant able to:

Read ☐Yes ☐No
Write ☐Yes ☐No

Can the participant indicate pain? ☐Yes ☐No

Please explain how:

_____

How does the participant adjust to new situations and new people?

_____

Does the participant have any routines that are significant for A Spark of Possibilities staff to be aware of? ☐Yes ☐No
If yes, please explain: _____
_____

Are transitions (moving from one activity/place to another) a challenge for the participant? ☐Yes ☐No
If yes, please explain and include details on strategies that are successful:
_____
_____

Special Equipment and Mobility

Participant is:
☐Ambulatory/Can walk independently
☐Semi-Ambulatory/Can walk with assistance
☐Non-Ambulatory

Adaptive Equipment:

Please check all special equipment that the participant will use and will be brought to A Spark of Possibilities
☐Glasses ☐Hearing Aids ☐Dental Retainers/Devices ☐Adaptive Utensils
☐Gait trainer/ ☐Walker ☐Crutches ☐ Orthotic Braces/ splints ☐Prostheses
☐Wheelchair (☐ Electric/ ☐ Manual/ ☐ Stroller) ☐Other: _____
Please describe participant ability to operate wheelchair (if applicable): _____
_____

Assistance in transferring? ☐Yes ☐No
What type of transfer is used? _____ Mechanical lift ☐Yes ☐No
Require range of motion exercises? ☐Yes ☐No *If yes, please attach copy of exercises*
Special Instructions/Other Information: _____
_____

Eating

Does the participant require special feedings (i.e. G-Tube, specialized diet)? ☐Yes ☐No
Please explain: _____
Special dietary needs (please be specific):
_____
_____

Can the participant feed themselves? ☐Yes ☐No
Please explain: _____
_____

Participant appetite is: ☐Good ☐Average ☐Poor
How many glasses of water does the participant typically drink per day? _____
Food Likes: _____
_____
Food Dislikes: _____
_____

Please provide needed utensils and supplies

Toileting and Hygiene

Does the participant have bladder control? ☐Yes ☐No
Does the participant have bowel control? ☐Yes ☐No
Does the participant need reminders/prompting? ☐Yes ☐No
Does the participant use the toilet on a schedule? ☐Yes ☐No
If yes, please provide schedule _____
_____

Does the participant need assistance during toileting? ☐Yes ☐No
If yes, please explain type of assistance needed _____
_____

Do you have a Bowel Program? ☐Yes ☐No
Bowel program medications must be included on the Medication List for Medication Administration at A Spark of Possibilities
☐ I have a different bowel program (please explain): _____
If appliable, is the participant independent in menstrual care? ☐Yes ☐No

Does the participant use the following (check all that apply)?
☐Urinal
☐Bedpan
☐Commode
☐Intermittent Catheter
☐Incontinent Products *If yes, please be sure to supply plenty of products to accommodate the entire day*
☐Menstrual Products *If yes, please be sure to supply plenty of products to accommodate the entire day*
Can the participant wash and dry hands ☐Independently ☐Needs Help
Explain further: _____

Recreation and Activities

Please list the activities (sports, hobbies, etc.) the participant currently participates in: _____
_____
Does the participant have any adaptive equipment to assist with participant in activities? ☐Yes ☐No
If yes, please explain: _____
_____
Does the participant have any limitations to being outside in the sun/heat for approximately 30 minutes at a time?
☐Yes ☐No
If yes, please explain _____
_____
Please list any activities the participant does not like:
_____
_____
What are the participants favorite things to do or learn about?
_____
_____
Are there any activities the participant should be exempt from for health reasons? ☐Yes ☐No
If yes, please explain: _____

Animal Room

Does the participant have any allergies to animals? ☐Yes ☐No
If yes, please explain _____
_____
Does the participant have any fear of animals? ☐Yes ☐No
If yes, please explain _____
_____

Sports and Games

What sports has the participant participated in previously? _____
Does the participant participate well in group activities? ☐Yes ☐No
If no, please explain _____
_____
Please list any indoor games/activities the participant particularly likes:
_____
_____

Arts and Crafts

What types of crafts or art (drawing painting, making bead necklaces, etc.) does the participant enjoy?
_____
_____
Are there any behaviors or limitations that would prevent the participant from participating in arts and crafts?
☐Yes ☐No
If yes, please explain _____
_____

Reviewed By: _____ Date: _____
Staff Signature