



We teach the mind to think, the hands to work, the heart to love.

Stepping Forward Counseling Center LLC

Therapeutic Summer Camp



We teach the mind to think, the hands to work, the heart to love.

Please Circle: Chatham | Nutley | Wall Township | Sleep Away | ABA

INSTRUCTIONS: Please verify and/or complete the entire application. Be sure to sign the Parent Authorization.

NAME OF CHILD	GENDER	D.O.B.	AGE	CHILD'S ADDRESS	CHILD'S HOME PHONE #

CHILD LIVES WITH MOTHER FATHER OTHER IF DIVORCED OR LEGALLY SEPARATED WHO HAS CUSTODY _____

GUARDIAN 1 INFORMATION

Relation to camper: MOTHER FATHER _____

Last Name _____

First Name _____

Street _____

City _____

State _____ Zip _____

Home Phone _____

Cell Phone _____

Business Phone _____

E-mail _____

GUARDIAN 2 INFORMATION

Relation to camper: MOTHER FATHER _____

Last Name _____

First Name _____

Street _____

City _____

State _____ Zip _____

Home Phone _____

Cell Phone _____

Business Phone _____

E-mail _____

PERSONS TO BE CONTACTED IN CASE OF EMERGENCY IF PARENT CANNOT BE REACHED

NAME	HOME PHONE	CELL PHONE	RELATIONSHIP
1.			
2.			

INDIVIDUAL PROGRAM PLANNING DATES

For Office Use Only

Date & Time

Date & Time

Intake / Evaluation _____

Progress / Follow Ups _____

Parent Session _____

Exit / Evaluation _____

PARENT AUTHORIZATION - A recent photo of your child is required with application. Please label with child's name.

- I agree to pay the annual tuition. Pre payment is due prior to the start of camp. In the event of 3rd party payment all claims are due to Stepping Forward Counseling Center, LLC. In the event a check(s) is/are received from an insurance provider and/or school, it is agreed that said check(s) will be designated as "payable to Stepping Forward Counseling Center" and the check(s) and explanation of benefits will be immediately forwarded to Stepping Forward.
- No refunds will be made for incidental absences or after camp has started.
- Stepping Forward is not responsible for any camper's belongings, either lost or damaged, while attending.
- If either parent or the emergency contacts cannot be contacted in an emergency, I hereby give Stepping Forward consent to bring my child to an emergency room or medical professional and authorize Stepping Forward to provide consent to secure necessary and proper medical treatment. I hereby authorize and direct Stepping Forward to administer medication as set forth in this application.
- Permission is hereby granted to the Directors of Stepping Forward to take my child on field trips as part of the regular program.
- Permission is hereby granted for photographs to be taken of my child during activities and Stepping Forward has the right to utilize these photographs in promotional materials.
- My child has permission to engage in all prescribed program activities, except as noted on the required medical form.
- Permission is hereby granted to Stepping Forward to transport my child to and from any off-site activities.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

NON-CUSTODIAL PARENT SIGNATURE _____ DATE _____

PARENTAL AUTHORIZATION MUST BE SIGNED

Enrollment Questionnaire - Counselor's Insight

Please provide the important information below:

Name of Child: _____

1. Case Manager (If Applicable) _____ Phone (____) _____ Child's School District _____

2. Please describe your child's school setting and goals: _____

3. What is your child's educational classification? _____

4. What is your child's diagnosis? _____

5. Please name and explain those things of greatest concern for your child (Include any physical limitations.) _____

6. Is your child physically aggressive? _____ 6a. Does your child bite? _____

7. Has your child ever been asked to leave a program? Please explain: _____

8. Do you consider your child more compliant or more oppositional? Please explain: _____

9. Please describe your child's attention span: _____

10. Please describe your child's language ability: _____

11. Please name and explain activities and areas of greatest success for your child: _____

12. Please describe previous summer camp experiences your child has had (be sure to include dates and place or name of camp): _____

13. Under what circumstances, if any, does your child become stressed or frustrated? _____

14. Is there a "nickname" your child likes to be called? _____

15. Is there anything you feel we need to know about your child? Please explain: _____

Strengths: _____

Weaknesses: _____

16. What is the swimming experience of your child? Circle one: Needs to learn. Wears floaties. A novice. Has experience. Swims in the deep end.

17. What are your child's fears? _____

18. Please name activities your child would most enjoy at Stepping Forward: _____

19. Please state YOUR requested goals for your child at Stepping Forward: _____

Decision for formal enrollment to program is based upon personal interview, observation and review of supportive information, after receiving the completed application and processing fee of \$300.

Please call Stepping Forward (973) 635-6550 as soon as possible to set up an appointment.

MAILING PREFERENCES

I would prefer mailings: E-MAILED MAILED
 If divorced please send mailings to: MOTHER FATHER BOTH OTHER

DAY CAMP DATES

Consecutive Weeks are Preferable	Parents Week					Sib Week			
	6/25-6/29	7/02-7/06*	7/09-7/13	7/16-7/20	7/23-7/26*	7/30-8/03	8/06-8/10	8/13-8/16*	8/20-8/24
	1	2	3	4	5	6	7	8	9

***4 Day Weeks**

*Please note that there is no session on the following dates: 7/4, 7/27 and 8/17.

*Please note the 7/26 and 8/16 session will run until 7pm.

FULL & HALF DAY PROGRAMS	1 Week (from above)	2 Weeks (from above)	3 Weeks (from above)	4 Weeks (from above)	5 Weeks (from above)	6 Weeks (from above)	7 Weeks (from above)	8 Weeks (from above)	9 Weeks (from above)
FULL DAY PROGRAM 9:00 AM - 4:30 PM	\$1,500	\$3,000	\$4,500	\$6,000	\$7,500	\$9,000	\$10,500	\$12,000	\$13,500

FINANCIAL INFORMATION / INSURANCE APPROVED**Please submit insurance information ASAP.**

Published rates are for Cash and Schools only. Other institutions are billed at a higher rate. Client is ultimately responsible for payment of all charges identified as "due amounts" which include: insurance payments forwarded to client; co-payments, intake fees, reinforcement fees, missed appointment fees; application fees and other fees and costs delineated by SFCC. SFCC shall submit applicable due amounts (identified as "insurance billed amounts") for reimbursement to client's insurance provider. Responsible party is absolutely obligated and agrees to pay to SFCC all insurance payments received by member directly from their insurance provider. Failure to pay insurance proceeds received by member shall be subject to collection by SFCC with client being responsible for all costs of collection, including attorney fees.

School District Contact: _____ Phone: _____ Fax: _____

A \$300.00 NON-REFUNDABLE PROCESSING FEE REQUIRED FOR ALL CAMPERS.

ADDITIONAL SERVICES

PLEASE CHECK SERVICES REQUIRED FOR YOUR CHILD. (ADDITIONAL FEES WILL APPLY) **NOT OFFERED DURING SLEEP AWAY DAYS.**

* Individual Aide Paraprofessional
 * Speech Therapy 1/2 hr/week 1 hr/week 1.5 hr/week * After-Care (\$10/hr 4:30PM to 6:30PM)
 * Occupational Therapy 1/2 hr/week 1 hr/week 1.5 hr/week Yes No
 * Academic Enrichment 1/2 hr/week 1 hr/week 1.5 hr/week

CREDIT CARD / CHECK INFORMATION

ENCLOSED IS MY: Check and/or Visa Master Card AmEx Amount \$ _____
 Card Number _____
 Security Code (Last 3 digits located on back of card in signature slip)
 Expiration Date Billing Address Street _____ Zip _____
 Cardholder Name (please print) _____
 Cardholder Signature _____

Year Round Office and Mailing Address: 26 Main Street, Chatham, NJ 07928

Year Round Phone: (973) 635-6550

Year Round E-mail: steppingforwardcounseling@msn.com

Website: www.steppingforwardcounselingcenter.com

T-SHIRT INFORMATION - Please check size for the FREE T-Shirt for Summer of 2012 (Predict size in summer)

YS YM YL AS AM AL AXL Additional T-Shirts are \$20 each.

Child Immunization Record

To be completed by
Physician's office.

Child's Name: _____ **DOB:** _____

Parent / Guardian Name: _____

MEDICAL CONTACT INFORMATION	
Pediatrician _____	Phone _____
Name	
Psychologist _____	Phone _____
Name	
Psychiatrist _____	Phone _____
Name	

HEALTH COMMENTS
Diet: Poor. Fussy. Needs improvements. Average. Good. Healthy.
Allergies: Yes or No Please list below under "other".
Diabetes: Yes or No
Asthma: Yes or No If yes, please list special instructions.
Comments what improvements:

VACCINE	DATE GIVEN
Diphtheria, Tetanus, Pertussis (if Td or DT please indicate*)	
LAST DATE OF TETANUS SHOT	
Polio Virus Vaccine	
Pneumococcal Vaccine	
Hepatitis B Vaccine	
Haemophilus B Vaccine	
Varicella (Chicken Pox Vaccine)	
Varicella	
MMR (Measles, Mumps, Rubella)	
MMR	
Other:	
1.	
2.	
3.	
4.	
5.	

* Requires medical exemption

Medical treatment consent form needs to be faxed.

Provisional Admission Attached - Date granted

Medical Exemption Attached

Religious Exemption Attached

Stepping Forward Counseling Center LLC

Medical Treatment Consent Form

As the Parent/Guardian of _____,

I give my consent for Stepping Forward Counseling Center to take any medical emergency treatment precautions necessary in case of injury or illness to ensure the safety of my dependent. I give permission for SFCC to provide first aid, and to contact the Emergency Medical Service to transport my dependent to the nearest hospital in order to treat him/her with serious injury and/or illness while on-site, or on off-site trips.

Signature of Parent/Guardian _____