Pennwood Adult Vacation Experience
The Arc of York and Adams Counties
June 16-20, 2025

2025 P.A.V.E. APPLICATION

I. <u>GENERAL INFORMATION</u>: (Please Print)

Name: _____

Date of Birth: _____ Age: _____

Address: _____
(Street) (City) (State) (Zip

Email: _____

Phone Number: _____

Emergency Contact: (Person familiar with camper, available from 10:00 AM - 3:00 PM)

_____ _____
(Name) (Telephone)

<u>COSTS AND FUNDING:</u>
The Adult Camp Pennwood fee is $390.00, payable at the time of application. MH-IDD funding may Apply.

<u>DEADLINES</u>
Please complete and return all forms and payment by May 1, 2025.
(Application, Release Form, Health Exam Form, Medical History Form, Confidential Household Survey)

Send your application to:

Alicia Zienkiewicz
The Arc of York and Adams Counties
497 Hill Street
York, Pa 17403

- Please note that registrations will be accepted on a first-come, first-served basis and that the number of registrations may need to be limited.

II. INDIVIDUAL SKILLS DEVELOPMENT:

To help us provide you with the most enjoyable summer possible, please describe in detail the following information about your needs:

Toileting (assistance with clothes or toileting/ Depends, constant supervision, independent, etc.)

Personal hygiene (washing hands, combing hair, menstrual care, etc.)

Dressing (buttons, zippers, putting clothes on, etc.)

Eating (physical assistance, utensils used, special diet, etc.)

Communications skills (non-verbal, sign language, language board, etc.)

Interactions with other adults (gets along well, fights, shy, etc.)

Behaviors (wanders off, easily upset, short attention span, etc.)

Aggressive behaviors and preventive techniques (hitting, biting, destroying property, etc.)

Activities: Sports, Arts and Crafts, Music (favorites, dislikes, needs, etc.)

Swimming skills (no experience, afraid of water, previous lessons, needs, etc.)

Allergies/Food Restrictions

Transfer Skills (if utilizing a wheelchair)

Did we miss anything? (Please include anything you think we should know.)

HEALTH EXAMINATION
BY LICENSED PHYSICIAN
FOR P.A.V.E.
Pennwood Adult Vacation Experience

I _____ authorize my physician to provide the following information. I understand that it will be used only by The Arc of York and Adams Counties' staff to help me during camp.

Signature: _____ Date: _____

All information is to be completed by a licensed physician.
I have examined the above applicant within the past twelve months.

Date of Exam: _____

Is the applicant free of infectious disease? _____ YES _____ NO
If no, please indicate type of disease: _____

Medication(s) prescribed: _____
_____

Please list any medications that will need to be administered during P.A.V.E. (10 a.m.-3 p.m.)
_____
_____

Are there any medical reasons why this patient should not attend an outdoor day camp with field trips in the community?
_____

Identify any medical problems that may place this applicant at an increased risk of medical emergency:
_____
_____

In my opinion, this condition **does/does not** preclude his/her participation in an active camp/community activity.

Health History (Circle if applicant has had any of the following):

Asthma/Breathing Difficulties	Heart Disease	Convulsions/Seizures	Hepatitis
Bleeding/Clotting Disorder	Diabetes	Hypertension	Tuberculosis
		Other _____	

Allergies:

Hay Fever	Poison Ivy	Insect Stings
Penicillin	Other Drugs	

Please explain if needed:
_____
_____

Operation or serious injuries (please explain):

_____

_____

Disability or chronic or recurring illness:

_____

_____

The applicant is currently under the care of a physician for the following conditions:

_____

_____

Instructions for management of applicant's seizure disorder (if applicable):

_____

_____

Current treatment (include medications and dosages):

_____

_____

Please list any orthotics or prosthetics which may be necessary at camp. List any special instructions required to use them properly.

_____

_____

Describe any prescribed meal plan or dietary restrictions:

_____

_____

Identify any allergies or asthma and proper treatment if individual experiences acute condition:

_____

_____

Date of last tetanus shot: _____

From completed by Dr. _____
(Please type or print)

Licensed Physician's signature: _____

Address: _____
(Street) (City) (State) (Zip)

Date form completed: _____

RELEASE FORM

CAMPER'S NAME: _____ DATE: _____

PHOTOGRAPHY CONSENT
I hereby grant permission for the staff of The Arc of York and Adams Counties or its designated representative to photograph me while participating in the daily activities of P.A.V.E. These photographs may be used for publicity for The Arc of York and Adams Counties in its newsletter or annual calendar or in the newspaper or other media.

Signature: _____ Date: _____

TRANSPORTATION CONSENT
I hereby grant permission to be transported on field trips in a van provided by Kelly Transit during PAVE.

Signature: _____ Date: _____

LEGAL CONSENT
Absent gross negligence or wrongdoing by The Arc of York and Adams Counties, I hereby release The Arc of York and Adams Counties, the Board of Directors and its individual members, P.A.V.E., its staff, counselors, volunteers, and any and all persons who assist in taking charge of the program and activities from any and all liability or claim arising from the accidental injury to, or death of me, incurred during or in transit to or from my participation in programs and activities from any cause whatsoever.

I further waive claim on The Arc of York and Adams Counties for any loss or damage to my property, whether in the program or en route to and from the program.

Signature: _____ Date: _____

I have witnessed the signing of these releases.

Witness: _____ Date: _____

The Arc of York and Adams Counties

MEDICAL HISTORY FORM

P.A.V.E.

NAME: _____ BIRTH DATE: _____ AGE: _____

HOME PHONE: _____ WORK PHONE: _____
ADDRESS: _____

EMERGENCY CONTACT:
NAME: _____ RELATIONSHIP: _____
TELEPHONE NUMBER: _____
ADDRESS: _____

PHYSICIAN'S NAME: _____ PHONE #: _____
DENTIST'S NAME: _____ PHONE #: _____

Do you have medical/hospital insurance? _____ If so, please indicate:

Carrier: _____ Policy or Group # _____
PA Medical Assistance Card (formerly ACCESS):
ID #: _____ PCS #PACs: _____

While attending P.A.V.E., I give permission to staff to use their own judgment in administering the following if needed:

_____ Tylenol _____ (indicate amount)
_____ Advil _____ (indicate amount)
_____ Benadryl _____ (indicate amount)
_____ Triple Antibiotic ointment
_____ Galadriel lotion
_____ Other _____ (indicate amount)

IMPORTANT -- THIS BOX MUST BE COMPLETED FOR ATTENDANCE

DAILY ADMINISTRATION OF MEDICATION/EMERGENCY AUTHORIZATION:

I give permission to personnel selected by the P.A.V.E. Coordinator to administer medication at my request and to apply routine first aid as needed.

I give permission for a physician to hospitalize, order x-rays, routine tests, and/or secure proper Treatment for me.

I certify that this health information, which I have supplied, is accurate and complete.

Signature: _____ Date: _____

Witness: _____ Date: _____

The Arc of York and Adams Counties
497 Hill Street
York, PA 17403
(717) 846-6589

THANK YOU FOR PARTICIPATING IN PROGRAMS OFFERED BY THE ARC OF YORK AND ADAMS COUNTIES.

1. We hope that you will be happy with your services. Despite all our efforts, there may be times that you do not agree or are unhappy with something about your services.

2. The Arc has a grievance policy -- which means that you can have your complaint reviewed by the appropriate Arc supervisor.

3. If you have a grievance, please ask for a grievance form. Assistance will be made available to complete the complaint process if needed.

4. When you have a formal complaint or grievance, it is The Arc's obligation to get back to you within one week. If more time is needed, The Arc supervisor is to call you to explain the delay and to tell you when to expect to hear from them.

5. If you are still unhappy and your complaint has not been resolved, you can file a grievance with MH/MR, OVR, or the organization which is funding your services.

THIS NOTICE IS TO BE PROVIDED TO ALL PROGRAM PARTICIPANTS BY THE DIRECT SERVICE PERSONNEL. IT IS TO BE EXPLAINED AND LEFT WITH THE PERSON(S) WHO WILL BE RECEIVING SERVICES OR THE GUARDIAN OR CARE-GIVER OF THE PERSON.

The Arc
York & Adams Counties

HOUSEHOLD SURVEY

The Arc of York and Adams Counties receives contributions and funding from many sources, including the United Way and the County of York. They have requested that we collect the following information. It is not mandatory for you to complete this form, but it will be appreciated, as it will help The Arc receive much needed funding.

Please check the gender of the person (s) who will receive services through The Arc of York and Adams Counties.
_____ Female _____Male _____Other

Please check the age range of the person (s) who will receive The Arc of York County services.
0-5 _____ 6-12 _____ 13-24 _____ 25-39 _____ 40-59 _____60+ _____

Please check the race or ethnic background of the person (s) who will receive The Arc of York and Adams Counties services
You may check more than one.

_____White (not Hispanic/Latino)
_____ African American/Black
_____ Latino/Hispanic Origin
_____ Other
_____ Asian
_____Hawaiian/Pacific Islander
_____ American Indian or Alaska Native
_____ multi-race

What is your total yearly income from wages or salary, self-employment, social security, pension, public assistance, rent, interest, or other sources? (Check one line only)

_____ Unemployed
_____ Less than $15,000
_____ $ 15,000-$24,000
_____ $ 25,000-$49,999
_____ $50,000-$74,999
_____ Over $74,000

Please indicate your Zip Code. _____

Name of individual receiving services: _____
Address: _____

Signature of person completing form (not required) _____

Please complete this form and return it to The Arc at this address:
Dept _____
The Arc of York and Adams Counties
497 Hill St.
York, Pa. 17403

This information will be kept strictly confidential. Thank you.

Rights of the Individual

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, practice the religion of the individual's choice and practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) An individual has the right to make choices and accept risks.

(f) An individual has the right to refuse to participate in activities and services.

(g) An individual has the right to control the individual's own schedule and activities.

(h) An individual has the right to privacy of person and possessions.

(i) An individual has the right of access to and security of the individual's possessions.

(j) An individual has the right to choose a willing and qualified provider.

(k) An individual has the right to choose where, when and how to receive needed services.

(l) An individual has the right to voice concerns about the services the individual receives.

(m) An individual has the right to assistive devices and services to enable communication at all times.

(n) An individual has the right to participate in the development and implementation of the individual plan.

(o) An individual and persons designated by the individual have the right to access the individual's record.

Individual Name: _____
(Please print)

Parent's/Guardian's Name: _____
(Please print)

Parent/Guardian Signature: _____

Date: _____