The Cambridge Program

"Helping Turn Disabilities into Capabilities"

August 16, 2017

Dear Friends,

It is time again to get ready for another year of programming. I hope everyone had a great summer and is ready for an exciting year. Welcome to all of our new applicants. Enclosed please find the 2017 – 2018 program application. Please fill it out in detail and send it back as soon as possible. Be sure to check off which programs you or your child/adult will be participating in. All of our programs fill up fast.

Preference will be given to our current participants. New participants will be accepted on a first come basis. Once all slots are filled, a waiting list will be generated, which will also be on a first come basis. **All applications are due by Saturday September 16th for current members to hold a spot.**

IMPORTANT: NEW APPLICANTS *- Anyone who was not a member last year or was on the waiting list will need to download this application, fill it out and send it AFTER August 28th to the address on page 2. No new applications will be accepted before this date. Applicants must be at least 8 years old.*

Checks should be made out to: *Cambridge Recreation, Special Needs.*

****Please do not send in an application without a check.***

Applications cannot and will not be accepted without payment.

Location: The Cambridge Program is located at 680 Huron Ave., Cambridge at the West Cambridge Youth Center. This is the old VFW site across from the golf course.

The Pool: The War Memorial Pool is located at 1640 Cambridge St. next to CRLS High School on. We will swim almost every Saturday throughout the year.

Russell Field Athletic Complex: 361 Rindge Ave. (Across from the towers)

The Department of Human Services: Our emphasis in all our programs will continue to be on health, fitness, wellness, understanding differences, building social interactions and safety. Every year the program continues to grow and thankfully, we get the continued support of Ellen Semonoff and Adam Corbeil from the Department of Human Services. Our fees are kept very low due to our fundraising efforts and the DHSP's commitment to children and adults of all levels and abilities.

Staff: Most of our dedicated staff will be returning this year. We will be hiring 3-4 new staff members in the upcoming weeks.

Special Olympic Form: If you are new to our program, please fill out a Special Olympic medical form and have it signed by a doctor or pediatrician. This form is very important and can be downloaded on DHSP website. **Please do not send a doctors/camp/school physical form**. We can only accept the attached Special Olympic form signed by a doctor.

The Cambridge Program

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2017-2018 Application

Dear Families,

Attached is an application packet for *The Cambridge Program*. Please fill it out in its entirety. The information that you provide is necessary in order to fully understand and meet your child/adult's needs. Please send your application in as soon as possible. All of our programs fill up fast. Applications will be accepted on a first come, first serve basis.

If your child/adult requires medication to be administered during any of the programs (pills, Epi-pen, etc.), a medical form (included in the application packet) must be completed by the prescribing physician prior to the start of the program.

Additionally, no medication will be accepted if it is not provided in the original bottle with current dosage information clearly stated on the front. Medication needs to be handed to the bus monitor by a parent/guardian. *THERE WILL BE NO EXCEPTIONS*. *For security purposes, please send a current photo with this application.

For participants over 22: Please list DDS case worker and contact information if possible.

In addition: Please note that participants over the age of 18 who are their own legal guardian must sign this application. No application will be accepted if some other person signs who is not the **legal guardian**.

Special Devices, Adaptations and Modifications- Any participant that uses a communication board and safety devices like: helmets, epi-pens, walkers, etc. **must send them in every Saturday.** It is not fair to the clients or our staff that work with them on the weekend. **We will not accept anyone that uses these adaptations during the week without them on Saturdays.**

Please return applications as soon as possible to:

David A. Tynes, Director of Programs For Individuals with Special Needs
51 Inman Street
Cambridge, MA 02139

Participant's Name: _____

Please check off the program(s) you wish your child/adult to participate in during the 2017-2018 school year.

1. _____ Saturday Recreation Program (680 Huron Ave) (Pool - 1640 Cambridge St)
   Ages: 8 - Seniors
   Time: 9:00am-3:00pm
   Start: October 7
   Fee: $110.00 per year
   - Transportation will be provided to and from the program

2. _____ Monday Evening Fitness Club (333 Rindge Ave)
   Ages: 18 years and older
   Time: 6:00pm-8:00pm
   Start Date: October 2
   Fee: $40.00 per year
   - Transportation will be provided to and from the program

3. _____ NEW Tuesday Night Vocational Training & Skill Development (Location TBA)
   Ages: 22 years and older
   Time: 6:00pm-8:00pm
   Start Date: TBA
   Fee: $40.00
   - Transportation will be provided to and from the program. This limited to 20 people.

4. _____ Wednesday Evening Fitness Club (333 Rindge Ave)
   Ages: 18 years and older
   Time: 6:00pm-8:00pm
   Start Date: October 4
   Fee: $40.00 per year
   - Transportation will be provided to and from the program

All checks should be made out to *Cambridge Recreation, Special Needs

Participant Information

Child/Adult Name: _____

Date of Birth: _____ Age: _____ Male/Female

Address: _____
City: _____ Zip: _____

Home Phone Number: _____
Email Address: _____
T-shirt Size: _____ Jacket Size: _____

Mother's Name (or caretaker if applicable):

_____

Address: _____
Email Address:_____

Phone # where you can be reached during program hours:
Home: _____ Cell: _____

Father's Name (or caretaker if applicable):

_____

Address: _____
Email Address:_____

Phone # where you can be reached during program hours:
Home: _____ Cell: _____

Guardian (other than parent): _____

Address: _____
Phone # where you can be reached during program hours:
Home: _____ Cell:_____

Medical Authorization and Consent

This program makes every effort to keep all participants safe. In the event of an emergency requiring medical attention, every effort will be made to contact the parent/guardian.

Participant's Name: _____

Program(s) your child/adult will be participating in (please list):

_____

If I (parent/guardian) cannot be reached, I authorize the staff from The Cambridge Program to transport my child/adult to the nearest hospital for emergency treatment.

_____ _____

Parent/Guardian Signature *Date*

Please list 2 emergency contacts other than yourself for your child/adult. These people should include adults with whom your child/adult may be released to in your absence.

In case of emergency, contact:

1. Name: _____

Address: _____

Phone: _____ Cell: _____

2. Name: _____

Address: _____

Phone: _____ Cell: _____

Photography Release/Field Trip Release

Please complete the following section:

_____ I do _____ I do not

give permission for my child/adult to be photographed for publicity purposes and to attend all scheduled field trips.

_____ _____

Parent/Guardian Signature Date

For safety & identification purposes, please attach a recent picture of your child/adult.

Participant Information

Please tell us about your child/adult. The more information we have, the better able we are to meet your child/adult's specific needs. Our mission is to help all participants grow within this environment. The following information helps us prepare for meeting your child/adult's needs. If you have any questions or concerns, please contact David at (617) 349-6829.

Please check all that apply:

Diagnosis:

_____PTSD(Post Traumatic Stress Disorder)
_____Intellectual Impairment
_____Down Syndrome
_____Physical Disabilities
_____Learning Disabled
_____Mental Retardation
_____Developmental Delay
_____Emotional Disabilities
_____Behavioral Disabilities
_____Traumatic Brain Injury
_____Nonverbal Learning Disability
_____ADD/ADHD
_____PDD
_____Autism
_____Aspergers
_____Cerebral Palsy
_____Fragile X
_____ Physical Disabilities
_____Trisomy 9
_____Other (Please specify)

Participant Information

What school does your child/adult attend (if applicable)?

School Name: _____
Address: _____
Phone Number: _____
Grade (if applicable): _____ Program Name (if applicable): _____

**For participants over the age of 22:*
What agency/program are they involved in (i.e. ARC, Vocational Placement, etc.?)

Agency/Program Name: _____
Address: _____
Phone Number: _____

My child/adult is:
_____Able to speak
_____Unable to speak
_____Able to use public transportation
_____Able to state own name, address, and phone number
_____Aware of any allergies he/she has

My child/adult is able to:
_____Get dressed on own
_____Use self-care skills (brush hair, brush teeth, etc.)
_____Toilet independently
_____Toilet with assistance_____
_____Is not yet toilet trained ***Where are they in the training process? Wipes, diapers, pullups and a change of clothes must be sent in for any participant not toilet trained.***

My child/adult communicates using:
_____Words
_____Communication board **(YOU MUST SEND ON SATURDAYS)**
_____Sign language (ASL)

My child/adult is able to:

_____Walk independently
_____Walk with assistance (crutches, cane, walker, etc.)
_____Needs a wheelchair

My child/adult's first language is:

_____English
_____Spanish
_____Creole
_____French
_____Portuguese
_____Chinese
_____Other (please list)_____

My child/adult is afraid of:

_____Being alone
_____Dogs
_____The dark
_____Bugs, bees
_____Loud noises
_____Masks, costumes
_____Being yelled at
_____Water
_____Large groups
_____Thunder
_____Cars, trucks
_____Other (please list)

Please list any other information that you feel is important in order for us to best service your child/adult:

_____

_____

I, _____ give my permission for
Parent/Guardian

_____ to take part in activities
Participant

and field trips that are offered during program hours.

_____ _____
Parent/Guardian Signature Date

Are there any activities that you DO NOT want your child/adult to participate in?

Please list: _____

_____

_____

If there are any other significant events or changes (i.e. death, divorce, traumatic experience) that you would like to share with us that will help us in servicing your child or adult, **please feel free to call me in confidence at (617) 349-6829**.

If there is any other information that you feel is important for us to know about your child or adult, please include that on this page:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Parent/Guardian Consent for Medication Administration

ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE BEARING THE ORIGINAL LABEL.

General Information

Name: _____

Date of Birth: _____ Age: _____ M/F

Name of Parent/Guardian: _____

Address: _____

Telephone: (home) _____ (work)_____

Telephone during program hours: _____

Other persons to contact if parent/guardian is unavailable:

Name: _____

Phone: _____ Relationship: _____

Please list all medications that the child/adult receives both at school and home:

1._____

2_____

3._____

4._____

Highly Important **Allergy Alert** Highly Important

Has this participant ever had an anaphylactic reaction? Yes or No

If the answer is yes, when was the last incident? Approximate date:_____

Was an Epi Pen used? Was the patient taken to the emergency room?

_____.

Please list specifically and in detail the food allergies or any allergy that this participant is allergic to:

1._____ 2_____ 3_____

4._____5._____6_____

Symptoms/Signs/Signals: What are the specific things a staff member should look for if this person is having an allergic reaction: Please List:

1._____2_____3_____

4_____.5_____6_____

Does this participant have an EPI PEN? Yes or No (Please Circle)

If yes, we will need an EPI Pen either left with us at program or one MUST be sent in each week. No Exceptions

Consent

I give permission for the Bonnie Wilkins, medical professional or David Tynes, program director to administer the following :

Medication (s): _____

Name of medication

Prescribed by: _____ (Licensed Physician)

Signature of Parent/Guardian _____

Medication Order
(To be completed by the child/adult's Doctor)

Name of child/adult: _____

Address: _____

If school age- name of school: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Specific Instructions: _____

Date of Order: _____ Discontinuation Date: _____

*Diagnosis: _____

*Other medical condition(s): _____

Special side effects, contradictions, reactions: _____

*Other medications being taken by the child/adult: _____

The date of the next scheduled visit or when advised to return to the

prescriber: _____

Consent for self-administration (if the nurse deems appropriate):

Yes _____ No _____

Name of Licensed Prescriber: _____

Address: _____

Business Telephone: _____

Emergency Telephone: _____

Signature of Licensed Physician: _____

Date: _____

IMPORTANT DATES

DATES ARE SUBJECT TO CHANGE

(All field trips and special programming will be announced at a later date)

Due to mandated staff trainings, as well as rehearsal and filming for Beauty and the Beast, Saturday Program will begin on Saturday October 7th.

October 2 – Monday Fitness Begin
October 4 – Wednesday Fitness Begin
October 7 – Saturday Program Begins
October 9 – OFF – Columbus Day
October 14 – Regular Program
October 21 – Regular Program
October 28 – Regular Program

This year's play, Beauty and the Beast, will be held on

Saturday December 16th at 7:00pm
Sunday December 17th at 4:30pm

Please mark your calendars!