Department of Communication Disorders

2016 Summer Speech-Language Specialty Clinics (SSC)

“Serving children since 1946”

SSC APPLICATION FORMS

1. Health History Form
2. Emergency Information
3. Participant Information
4. Activities of Daily Living
5. Final Report Distribution Consent
6. Consent Form-Campus-wide Activities
7. Consent Form-Photos/Videos and Audio Recordings
8. Financial Assistance Application
9. Michigan ELKS Assistance Form
10. Code of Conduct for Participating Individuals
Please complete front and back of this form, sign it, and return to the SSC Coordinator. All information is confidential and used only by SSC or potential emergency personnel to meet the needs of your child.

**Medical Information:**

Child’s name ____________________________  Birth date ________  Age ______

Parent/guardian name ____________________________

Address

Family Physician’s first & last name ____________________________  Phone ____________________________

Family Physician’s address

Medical Insurance provider ____________________________  Policy number ____________________________

Subscriber’s name ____________________________  Birth date ________  Relationship to child ______

**Health History:** Please check all that apply

- [ ] Asthma/breathing difficulty
- [ ] Heart condition
- [ ] Diabetes
- [ ] ADD/ADHA
- [ ] Has had Chicken Pox
- [ ] Seizures/epilepsy
- [ ] Dizziness/fainting
- [ ] Physical disability
- [ ] Treatment for emotional or behavioral difficulties
- [ ] Wear glasses/contacts or hearing aids
- [ ] Recent illness, injury, infectious disease
- [ ] Recent surgery/hospitalization
- [ ] Chronic or recurring illness/condition
- [ ] Skin problems (rash, acne, etc.)
- [ ] Frequent ear infections
- [ ] Chest pain during/after exercise
- [ ] Frequent headaches/head injury
- [ ] Bleeding/Clotting disorder
- [ ] Past serious injury/illness
- [ ] Problems w/constipation or diarrhea
- [ ] Back/spinal problems
- [ ] Significant life event (abuse, death, family change)

Please explain any conditions checked above.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Form #1 – Health History Form
**Allergies:** Please check all that apply and list specific food, medication, or environmental allergies including reaction and treatment given.

- [ ] Food allergies
- [ ] Latex
- [ ] Hay fever
- [ ] Penicillin
- [ ] Insect stings
- [ ] Other drugs

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**Special needs:** Please list any additional health concerns, behavioral issues, or circumstances which staff should be aware of to meet the needs of your child.

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**Immunizations:** Please list the month/year of immunizations, leave blank if not received.

- DPT (Diphtheria, Pertussis, Tetanus) __________
- Tetanus Booster __________
- Polio __________
- MMR (Measles, Mumps, Rubella) __________
- HIB (Haemophilus Influenza B) __________
- Tuberculin Test __________
- Chicken Pox (Varicella) __________
- Hepatitis B __________

**Medications:** Any necessary medications must be administered by parent/guardian. If your child needs medication during SSC, please make arrangements with the clinical instructor. If your child carries an inhaler or allergy medications, please inform the SSC Director and Clinical Instructor.

**Authorization:** My child has permission to engage in all prescribed SSC activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give my consent for the SSC staff to obtain necessary emergency medical treatment for my child with the understanding that I or other listed emergency contact designee will be notified as soon as possible.

Signature ___________________________ Date ___________ Phone # ___________

Printed name ___________________________ Relationship to child ___________________________
Department of Communication Disorders
Summer Speech-Language Specialty Clinics

Emergency Information

Child’s Name ____________________________ Birth date ____________ Age ____________

Parent/Guardian Signature ______________________________________________________

Name (Print) ________________________________________________________________

Address _____________________________________________________________________

Day Phone _______________ Email __________________________

ALTERNATE PERSON TO CALL IF PARENT/GUARDIAN CANNOT BE REACHED

Name ____________________________ Relation to child __________________________

Address _____________________________________________________________________

Day Phone ________________________ Home Phone ______________________________

AUTHORIZED DROP-OFF / PICK-UP / CHECK-OUT

Only the people listed below will be permitted to drop-off, pick-up, or check this child out of the Summer Clinics. Include names of parents or guardians, plus relatives, etc.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
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<tbody>
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Parent or Guardian Signature ____________________________________________ Date ________________________

Form #2 – Emergency Information
The information contained below will be helpful to the Summer Speech-Language Specialty Clinics staff in evaluating your child’s upcoming participation in this summer’s program. Your input as a primary adult in your child’s life is vital to our assessment. Please complete and return this form with the other enclosed forms.

1. If applicable, how many summers has your child attended this program? ________________
2. What type of communication disorder is your child in therapy for? ________________

Please rate your child in each of the areas below using a scale of 1 (poor) to 7 (excellent). Make an “X” on each line according to how you would rate your child. Please use the space below for additional comments.

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>(Poor)</th>
<th>(Excellent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1---- 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>1. Self-esteem</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>2. Independence in large group</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>3. Independence in free play</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>4. Interaction with other children</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>5. Confidence</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>6. Interaction with other adults</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>7. Willingness to speak in a crowd</td>
<td>+------+------</td>
<td>+------</td>
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<tr>
<td>8. Willingness to participate in group</td>
<td>+------+------</td>
<td>+------</td>
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<tr>
<td>9. Your ability to understand child’s speech</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>10. Overall social independence in group</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>11. Others’ ability to understand child’s speech</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>12. Courtesy</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>13. Attentiveness</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>14. Cooperation with peers</td>
<td>+------+------</td>
<td>+------</td>
</tr>
<tr>
<td>15. Friendliness with peers</td>
<td>+------+------</td>
<td>+------</td>
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</table>

COMMENTS:

____________________________________  __________________________
Parent or Guardian Signature                        Date

Form #3 – Participant Information
# Department of Communication Disorders
## Summer Speech-Language Specialty Clinics
### Activities of Daily Living

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Birth date</th>
<th>Age</th>
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</table>

### Feminine

<table>
<thead>
<tr>
<th>Hygiene:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>_______</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>_______ Can do everything on her own</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______ Needs help:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______ remembering to change sanitary napkin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______ remembering to bring products to events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______ proper disposal of sanitary napkin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Toileting:

| _______ Can do everything on his/her own |  |  |
| _______ Needs help: |  |  |
| _______ being reminded to use toilet |  |  |
| _______ wiping properly |  |  |
| _______ remembering to flush |  |  |
| _______ remembering to wash hands |  |  |
| _______ wears diapers |  |  |

### Hand washing:

| _______ Can do everything on his/her own |  |  |
| _______ Needs help: |  |  |
| _______ being reminded to wash hands |  |  |
| _______ adjusting water |  |  |
| _______ being reminded to use soap |  |  |

### Walking:

| _______ Child can walk to all activities independently |  |  |
| _______ Restricted walking distances, please explain: |  |  |

### Meals (for full day participants):

| _______ Can do everything on his/her own, or |  |  |
| _______ needs help with |  |  |

### Allergies or food restrictions:

### T-shirt size:

- [ ] Adult small
- [ ] Adult medium
- [ ] Adult large
- [ ] Adult x large
- [ ] Child small
- [ ] Child medium
- [ ] Child large
- [ ] Child x large

### Parent or Guardian Signature

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Date</td>
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</tbody>
</table>

Form #4 – Activities of Daily Living
Department of Communication Disorders
Summer Speech-Language Specialty Clinics
Final Report Distribution Consent

Child’s Name ___________________________ Birth date _______________ Age __________

At the conclusion of the Summer Specialty Clinics Program, Final Reports will be distributed. In addition to parents or guardians, please list with COMPLETE NAMES and ADDRESSES places reports should be sent. Thank you.

Complete name

Street address

City

State Zip Code

Complete name

Street address

City

State Zip Code

Complete name

Street address

City

State Zip Code

Permission is granted to Central Michigan University – Summer Specialty Clinics to release copies of this summer’s Final Report for ___________________________ to the above-specified persons.

(child’s name)

Parent or Guardian Signature _________________________ Date _________________________

Form #5 – Final Report Distribution Consent
Department of Communication Disorders
Summer Speech-Language Specialty Clinics

Consent to Participate in
Campus-wide Activities

Child’s Name ________________________________ Birth date _______________ Age ________

I hereby give permission for my child ________________________________ to participate in activities in various locations on the campus of Central Michigan University for the duration of Summer Speech-Language Specialty Clinics.

Activities may include outdoor playing and walking trips to locations of interest on campus.

I understand that my child will be accompanied and actively supervised at all times by a responsible adult and that his/her whereabouts will be known by the SSC Director and the Administrative Secretary at the front desk of the Carls Clinic.

I have reviewed and understand the SSC Code of Conduct, and I have reviewed the SSC Code of Conduct with my child.

Parent/Guardian’s Signature ____________________________________________

Printed name of above signature _________________________________________

Relationship to child ___________________________________________________ Date __________________

Form #6 – Consent to Participate in Campus-wide Activities
Child’s Name ___________________________ Birth date ________________ Age ________

I hereby give my consent to have the following types of images and recordings made of ____________________________.

(Print child’s name)

_____ Photographs  
_____ Video recordings  
_____ Audio recordings

I understand that these images/recordings or comments may be used by CMU Summer Specialty Clinics for the purposes indicated below: (Please initial if permission is granted)

_____ Educational materials prepared for presentation in a CMU CDO class

_____ Educational materials prepared for presentation at fund-raising events

_____ News releases to the following media:

_____ Midland Daily News

_____ Morning Sun

_____ Summer Clinics Newsletter

_____ CMU Life

_____ WCMU-TV

_____ Marketing of CMU’s clinical services (clinic flyers, brochures, presentations, and website)

_____ Marketing of CMU’s educational programs (flyers, brochures, presentations, and website)

_____ Observation by parents of other children in the participant’s classroom

_____ SKIT and other camp performances

_________________________________________  ____________________________________
Parent or Guardian Signature  Date

Summer Specialty Clinics/Department of Communication Disorders HIPAA media consents as per department procedures

Form #7 – SSC Consent for Photography, Video and Audio Recording
Child’s Name ___________________________ Birth date ___________________________ Age _________

SSC is able to offer limited partial scholarships to campers each summer based on financial need and availability of funds donated by our generous community groups and individuals. If you are requesting funding for your child to attend SSC 2016 you must complete the following information along with the ELKS REQUEST FOR ASSISTANCE, by May 1, 2016 and mail to MaryBeth Smith, SSC Coordinator, 2189 Health Professions Building, Mount Pleasant, MI 48859. Please note that not all clients that request a scholarship will be awarded a scholarship.

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name:

Parent/Guardian Address:

Parent/Guardian Phone:

Parent/Guardian E-mail Address:

PARENT/GUARDIAN HOUSEHOLD AND FINANCIAL INFORMATION

Total number of persons living your household:

Please enter the Monthly Gross Income for those responsible for SSC fees:

Total amount of household income:

Have you requested a scholarship from us before?

Do you have any special circumstance that we need to consider?

☐ I certify that the above information is true and complete to the best of my knowledge.

Signature: ___________________________ Date: ___________________________

Form #8 – Financial Assistance Application
Michigan Elks Association
MAJOR PROJECT COMMISSION
P.O. Box 1134
Big Rapids, MI 49307-0834
(231) 796-5775

REQUEST FOR ASSISTANCE FROM
MICHIGAN ELKS MAJOR PROJECT FOR SPECIAL NEEDS CHILDREN

This information will be used by the Elks Major Project Commission to consider assistance to be given to the child whose case is outlined below. This form is to be filled out by a member of the Benevolent and Protective Order of Elks, making a personal investigation of conditions and having knowledge that the information is true and correct. All items must be answered so that the report will be of maximum value in studying the merits of the case.

RETURN THIS FORM TO SUMMER SPEECH AND LANGUAGE SPECIALLY CLINIC
ATTN: MARYBETH SMITH, SSC COORDINATOR

Name
(Last)          (First)        (Middle)
Address
(Street)        (City)         (Zip Code)      (Tel. #)
Sex             Present Age     Birthdate
Child's Ailment?

From what other agencies or organizations has help been requested?

What assistance has been received?

Recommended Help By Dr. or Agency
Tel. #

Name of Doctor to contact regarding child's condition

Address
(Street)        (City)         (Zip Code)      (Tel. #)
Has the child been hospitalized for the Ailment? When?
Where?

Has the child been to an out-patient clinic? When?
Where?

Will the parents or guardian consent to a medical examination by a doctor, at the expense of the Michigan Elks Association Major Project Commission?

What help is requested from the Elks Major Project For This Special Needs Child? (Please be as specific as possible.)

Estimated Cost

Payment Schedule

(SEE OTHER SIDE)
Family Report

Father's Name (IF STILL MARRIED) ____________________________ Age ________

Occupation ______________________________________________ Whole or Part Time? _______

By Whom Employed ________________________________________

Mother's Name ____________________________ Age _______

If Employed, State Occupation ____________________________ Whole or Part Time? _______

By Whom Employed ________________________________________

Marital Status of Parents (Married, Separated, Divorced, Widowed, etc.) ______

Do they carry Medical or Hospital Insurance? ____________ Is child covered? ______

Name of Insurance Company ______________________________

Total monthly gross income of family from all sources $ ________ Number of dependent children living at home _______

PLEASE NOTE:
A copy of the parents or guardians 1040 Federal Tax form must accompany request for assistance form.

HOLD HARMLESS CLAUSE

I, ____________________________________________, as the parent or legal guardian of the above-named (child) (recipient) (applicant), understand that the persons rendering services, professional and otherwise, are independent of and not employees, servants or agents of the Elks Major Project Commission nor are they in any manner under its direction or control.

As the parent and/or legal guardian, I do agree to hold the Elks Major Project Commission harmless from any claim for or on behalf of myself or the (child) (recipient) (applicant) for any damages, whether from physical injury or otherwise, arising out of the transportation to and from, if provided, any examination, treatment, consultation or program, or during the course of any examination, treatment, consultation or program, in which the above-named (child) (recipient) (applicant) participates.

Dated ________________________________ Parent and/or Guardian's Signature ____________________________

Information below is to be filled out by Lodge Chairman Only

My recommendations in this case are as follows: ________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Enclose any additional information that will be helpful in evaluating the application, letters, photographs, etc.

SIGNATURES REQUIRED

Lodge Name ________________________________ Lodge Chairman ________________________________

Address ______________________________________ Address ______________________________________

City ________________________________ Zip ________________________________

Exalted Ruler ________________________________ Chair Phone # ________________________________

Is family of applicant an Elk. Yes ______ No ______

THIS APPLICATION MUST BE COMPLETELY FILLED OUT BEFORE APPROVAL CAN BE OBTAINED.

Date ________________________________

App. 4 Rev. June 2008 #76937
INTRODUCTION

Children attending the Summer Speech-Language Specialty Clinics (SSC) will attend large and small group programs and participate in activities with a number of children who come from backgrounds different from their own. It is critical that children attending the Summer Speech-Language Specialty Clinics have a safe and positive environment in which they can improve their communication skills. We are asking all parents to review the Summer Speech-Language Specialty Clinics Code of Conduct with their child before the program begins. Parents of preschool-aged children are asked to adapt these concepts to meet the same intent for their young children.

The staff of the Summer Speech-Language Specialty Clinics believes that teaching self-discipline and responsibility are one of the most critical behaviors a child can learn. We are committed to helping children improve these behaviors by stressing the following:

Respecting the rights of others – Participants must work without disruption, show courtesy towards others, cooperate to help others learn, use appropriate language, and feel good about themselves in a large group environment.

Taking responsibility for learning – Participants must strive for excellent communication skills, practice their communication skills in all programs, become good listeners, and do their work in a timely and cooperative manner in a large group environment.

Acting in a safe and healthy way – Participants will use all SSC materials appropriately including furniture and room fixtures, follow SSC rules at all times, and keep their hands and feet to themselves.

Treating all property with respect – Participants will take care of all SSC property including recreation materials, respect other participants’ property, and use the property of others ONLY with permission from that individual.

RECREATION RULES

The following activities are not allowed during the Summer Speech-Language Specialty Clinics program.

- Play fighting
- Kicking, hitting, fighting, wrestling, pushing, or shoving
- Throwing balls at the inside or outside walls of buildings
- Using vulgar or obscene language

Participants entering all CMU buildings are expected to walk in a quiet manner while in their classroom lines, and do so with only verbal redirection.

Form #10 – Code of Conduct for Participating Individuals
CONSEQUENCES FOR POOR CHOICES MADE BY SSC PARTICIPANT

We fully expect that our participants will attempt to follow the rules we have set for them. However, there are times that the participants will choose not to follow the SSC rules. A set of consistent positive and alternative consequences will be implemented, based upon each individual participant’s own choice-making. Please remember that these are not punishments, but simply consequences for poor behavioral choices.

Participants are expected to follow the requests of the clinicians and staff members of the Summer Speech-Language Specialty Clinics. Behavior that is disruptive, disobedient, destructive, or dangerous to self or others will be subject to appropriate consequences. The more severe and persistent the behavior, the stronger will be the consequence.

Staff members will complete a behavior incident report form when they believe their efforts are not effective in bringing about the necessary positive behavior of the participant. The SSC Director will review the incident form and proceed as follows:

1. The problem will be discussed with the participant. The participant will have an opportunity to tell his/her perception of the problem.
2. All available testimony and evidence will be gathered and evaluated and then an appropriate consequence for the child’s poor choice behavior will be implemented.
3. The consequences, under normal circumstances, will be progressive in nature. However, if the behavior is considered unusually serious (for example, fighting, vandalism or other dangerous behavior) the camper will be given a more serious consequence immediately.

It is our intention to notify parents/guardians of positive and negative student behaviors through telephone or writing. Please feel free to contact the SSC Director if you have any questions regarding the social progress of your child.

CONSEQUENCES FOR PARTICIPANTS REFERRED TO THE SSC DIRECTOR

The consequences administered may include, but are not limited to, the following actions:

1. **Warning.** This will include a conference with the director and may involve a treatment plan for improvement of behavior.
2. **Parent conference.** The conference will include the director, parent, participant, and staff member(s) to discuss strategies for improvement of the behavior. This conference will be held when appropriate and may occur during the week.
3. **Temporary camp suspension.** One (1) to five (5) days suspension for serious offenses (fighting, vandalism, theft).
4. **Expulsion for program.** This will be enforced if the participant presents a clear danger to themselves or other participants, and will be based on a pattern of behavior.

Form #10 – Code of Conduct for Participating Individuals