

Referred by: _____

**CAMP FATIMA
EXCEPTIONAL CITIZENS' WEEK
CAMPER Request / Waitlist Form**

For Office Use Only:
Received: _____
Initials: _____

INSTRUCTIONS: Thank you for your interest in attending Camp Fatima's Exceptional Citizens' Week. E.C. Week is for children and adults (ages 9+) with physical and mental challenges. **THIS IS NOT AN APPLICATION.** This is a Form to place your child/ward on our WAITING LIST.
New Campers: An assessment is required for all new Campers. The information you provide on this Form will be used to assess if your child/ward is eligible to attend E.C. Week. If you have special comments or remarks concerning your child/ward, please use the reverse side of this Form. Once we determine your child/ward is eligible and when space becomes available, we will send you a comprehensive application to complete and submit. Selected Campers should receive applications by February.
Returning Campers: This Form is also used for returning Campers to request an application for future years.
Note: If you move or change your phone number, please update and re-submit this Form.

CAMPER INFORMATION:

PLEASE PRINT OR TYPE

Child/Ward Name - First: _____ Last: _____

Gender: Male Female

Date of birth: ___ / ___ / _____ Age: _____

Medical Diagnosis / Equipment (please check all that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Mild Mental Retardation | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Wheelchair / Stroller |
| <input type="checkbox"/> Moderate Mental Retardation | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hoyer Lift |
| <input type="checkbox"/> Severe Mental Retardation | <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> G-tube |
| <input type="checkbox"/> Profound Mental Retardation | <input type="checkbox"/> Other PDD | <input type="checkbox"/> Vision Impaired | <input type="checkbox"/> Catheter |
- Other medical diagnoses/syndrome, please describe below:

Additional Information: _____

Communication Device, if applicable: Board ASL Book

Does Child/Ward Currently Receive Medication? Yes No

School/Day Program (if applicable): _____

Where does Child/Ward live? Parent/Guardian home Other location, please specify:
Name: _____

Has Child/Ward attended before? _____ If yes, last year attended? _____ Total # of Years attended E.C. Week: _____

PARENT / GUARDIAN INFORMATION:

Parent / Guardian Name(s) (first, last): _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Home #: _____ Cell/Work/Pager #: _____

E-mail: _____

Signature of Parent/Guardian: _____ Date: ___ / ___ / _____

(OVER FOR SPECIAL REMARKS →)

ALL CORRESPONDENCE SHOULD BE ADDRESSED TO:
Camp Fatima E.C. Week
P.O. BOX 206
Gilmanton I.W., NH 03837-0206
Phone: 603-364-5851 Fax: 603-364-5038
For more information, please visit www.ecweek.org or www.campfatima.org