BAY CLIFF HEALTH CAMP – CHILDREN'S SUMMER CAMP *(CSC)*
INITIAL REFERRAL FORM AND PERMISSION TO SHARE INFORMATION

The purpose of this form is twofold. First, to refer a child for *possible* participation in Bay Cliff - Children's Summer Camp *(CSC)* in Big Bay, MI. Second, to grant permission for information to be shared with Bay Cliff from school, physicians, health care professionals, and other agencies.

Dates of *CSC*: June 15/16 to August 3, 2019 -half summer for preschool-aged children-

Most of our campers are in cabins with 4-6 other children, and one counselor (exceptions are pre-school aged children, and our children with greater physical support needs). In this setting will this child be able to: transition with the group, be safe during unstructured time, tolerate the camp setting (busy, loud, bright, hot), tolerate changes to schedule, follow directions from more than one person and participate in small and large group activities?

***CSC* – Eligibility Basics**

- ✓ 3-17 years of age
- ✓ In need of skilled therapy for habilitation or rehabilitation – this means currently receives or recommended by medical professional
- ✓ On the same medications to support attention/behavior for at least 30 days prior to camp (if applicable)
- ✓ Safe in camp setting with self and others
- ✓ Able to function in camp/group setting as mentioned above

Each Unit (I, II, III, IV, V) has additional expectations of behaviors and/or abilities for the children within them. These are available on our website or upon request.

Release of Information: I, the parent/legal guardian of _____, give permission for information about my child -including medical records- to be shared with Bay Cliff Health Camp in order to be referred and considered for possible admission to Bay Cliff – Children's Summer Camp *(CSC)*. I also give permission for Bay Cliff personnel to contact me.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

REFERRAL INFORMATION (To be completed by therapist or other health care professional)

Name of Minor: _____ Gender: M / F Birth Date: _____

School Eligibility: _____ Medical Diagnosis/es: _____

Parent/Legal Guardian Name(s) _____

Mailing Address: _____

Phone: _____ Email: _____

School: _____ Grade: _____

Teacher/s: _____ Principal: _____

Referral made by: _____ Position/Relationship: _____

Phone: _____ Email: _____

Current Health Care Professionals (please include information to contact via preferred method):

Physician _____

OT/PT/SLP _____

OT/PT/SLP _____

OT/PT/SLP _____

Other (_____) _____

Please return completed form to Bay Cliff Health Camp, PO Box 310 Big Bay, MI 49808 or baycliff@baycliff.org
***Want more information or another form? www.baycliff.org ***
****Have a question? Call (906)345-9314 or email baycliff@baycliff.org****