Summer Youth CAREER EXPLORATION

APPLICATION

Important Information

- Each application will be reviewed to determine if the selection made is appropriate for the student.
- The Summer Youth Boot Camp cannot provide personal care, an aide, or nursing services.
- Students are required to bring a packed lunch (no microwave foods).
- Transportation to and from camp is not provided.

*In order to complete your application, the following forms must be completed and returned to our offices, **no later than May 17, 2019**.

__ Application

__ Emergency Medical Form

__ Release of Information

__ Sign and date Policy and Procedures Form (located in back of handbook)

*Remember your camper will not be registered until all forms are completed. Camp slots are filled on a first-come, first-served basis, determined by when all forms are received.

Mail all applications to:

Montgomery County Residents

Andrea Harker
MCBDDS
8114 North Main Street
Dayton, OH 45415
Phone: (937) 329-4723
Email: aharker@mcbdds.org
Fax: (937) 890-7456 Attn: Andrea Harker

Greene County Residents

Kathy Kleiser
GCBDDS
245 Valley Road
Xenia, OH 45385
Phone: (937) 562-6529
Email: kkleiser@greenedd.org
Fax: (937) 562-6539 Attn: Kathy Kleiser

Provided by:

MONTGOMERY COUNTY Board of Developmental Disabilities Services

GREENE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES GCBDD A Lifetime of Dignity and Opportunity

EMPLOYMENT FIRST

Application

Part 1: Camper Information

First name: _____ Last name: _____ Gender (circle): M F

Current Age: _____ Date of Birth: _____ (MM/DD/YYYY)

School: _____ Grade: _____

Teacher (Responsible for IEP): _____

Is the student connected with Montgomery or Greene County DD services? Yes No

Would you like more information about eligibility? Yes No

Is the student connected with Opportunities for Ohioans with Disabilities (OOD)? Yes No

Name of OOD counselor? _____

Does the student have any paid employment or volunteer experience? Yes No If yes, please list below:

Paid employment: _____

Volunteer: _____

Part 2 - Guardian Information

First name: _____ Last name: _____

Relationship to Camper: _____

Cell phone: _____ Other Phone: _____

Address: _____ Apt.: _____

City: _____State: _____ Zip: _____

Email address: _____

Second Guardian (Optional)

First name: _____ Last name: _____

Relationship to Camper: _____

Cell phone: _____ Other Phone: _____

Address: _____ Apt.: _____

City: _____State: _____ Zip: _____

Email address: _____

Part 3: Career Exploration Section Selection

Directions: Please rank Sessions 1-2, from most desired to least desired (i.e. 1st, 2nd).

_____**Session 1** June 3-June 7 _____**Session 2** June 10-June 14

Greene and Montgomery County Boards of DD Boot Camp Emergency Medical Form

Name:					
Address:					
City:	State:	Zip:	Phone:	DOB:	
School District/School Attending:				Teacher:	

Guardian: ☐ No ☐ Yes Guardian Name: _____ Phone: _____

☐ **I give consent for:** ☐ **I do not give consent for:**

1. Transfer to the most accessible hospital, if needed. Hospital of preference:
2. Emergency medical treatment, as needed, by a licensed physician or dentist, and in the event emergency treatment is necessary, please contact: ***(Must list two contacts)***

NAME	RELATIONSHIP	HOME PHONE#	CELL PHONE#	WORK PHONE#

MEDICAL TREATMENT INFORMATION	NAME	OFFICE PHONE
Primary Physician:		
Dentist:		
Other:		
Insurance Provider:	Policy Number:	

Sensitivity to heat/cold or other weather conditions ☐ Yes ☐ No (If yes, explain):

ALLERGIES *(include allergies to medications):*	CURRENT MEDICATIONS:

Medical condition, disability or physical impairments (diabetes, heart disease, seizures, vision impairment, hearing impairment, etc.):

Additional Information - Is assistance needed for hygiene or health needs? Please explain.

COMMUNICATION:	☐ Verbal	☐ Non-Verbal	☐ Uses Sign Language	☐ Uses Gestures	
	☐ Other communication devices				
MOBILITY:	☐ Without assistance	☐ With assistance	☐ With walker or cane		
	☐ Uses wheelchair	☐ Uses wheelchair on outings			

BEHAVIOR SUPPORT PLAN: ☐ **Yes- attach BSP** ☐ **No**

BEHAVIORAL CONCERNS:	DIETARY INFORMATION/MEALTIME EQUIPMENT:
EVACUATION CONCERNS:	**SELF CARE:**

Signature of Person Completing Form _____ Relationship _____ Date _____

Signature of Guardian or Individual _____ Date _____

MONTGOMERY COUNTY

Board of Developmental Disabilities Services

Consent for Publication of Personally Identifiable Information

As part of its advocacy efforts on behalf of people with developmental disabilities, the **Montgomery County Board of Developmental Disabilities Services** (MCBDDS) seeks to provide information to the public through various programs and activities, events, facilities, staff, and the individuals and families it serves.

Before **personally identifiable information** is shared, individuals (or their legal guardians) must consent to the release of said information, which may include – but is not limited to – their name, likeness, voice, work, personal or background information and achievements.

This consent form releases MCBDDS from any liability associated with violation of privacy, confidentiality, personal or property rights that individuals or their guardians have in connection with such materials. Consent also affirms that individuals or their guardians a) waive any right to approve said materials, and b) understand that their participation is voluntary, and will not lead to financial compensation of any type.

The Montgomery County Board of Developmental Disabilities Services has my permission to use my/my child's name, likeness, voice, work, personal or background information and achievements for community awareness, news or promotional purposes. I understand that publication may encompass presentations as well as print and electronic vehicles, including websites, videos, news outlets, social media sites, and more.

In granting this consent, I release and hold harmless the Montgomery County Board of Developmental Disabilities, its agents and successors, from liability or harm that may result from the publication of such materials.

I understand that this authorization may be revoked or cancelled at any time (except to the extent that action has been taken in reliance on it) by notifying, in writing, the MCBDDS Communications Specialist at 5450 Salem Avenue, Dayton, OH 45426 or via e-mail at communityrelations@mcbdds.org.

Printed name of individual who is the subject of the release: _____

Individual Consent

☐ **I GIVE CONSENT** ☐ **I DO NOT GIVE CONSENT**

I am of full age and am my own guardian. I have read this release or had it explained to me, understand its contents, and agree to allow MCBDDS to publish my personally identifiable information for a period of one year from the date specified below.

_____ _____

Signature of Individual Date

Guardian Consent

☐ **I GIVE CONSENT** ☐ **I DO NOT GIVE CONSENT**

I am the parent and/or legal guardian of the person or minor named above, and have the legal authority to execute the above release. I have read this release or had it explained to me, understand its contents, and agree to allow MCBDDS to publish the personally identifiable information for a period of one year from the date specified below.

_____ _____

Signature of Parent or Legal Guardian Date

GREENE COUNTY BOARD
OF DEVELOPMENTAL DISABILITIES
GCBDD
A Lifetime of Dignity and Opportunity

245 N. Valley Road
Xenia, OH 45385

(937) 562-6500
Fax (937) 562-6520
www.greenedd.org

I,_____, self/parent/guardian of
_____, give the Greene County Board of Developmental Disabilities (GCBDD) permission to use my/his/her photograph or other image on television, billboards, newspaper, newsletters and/or other forms of print media to help educate the public about programs the Board offers to Greene County residents who are developmentaly disabled.

x_____ Date _____
(self/parent/guardian)

x_____ Date _____
(witness)

TRANSITION SERVICES

Greene County Board of Developmental Disabilities

245 North Valley Road • Xenia, OH 45385 • (937) 562-6500 •Fax (937) 562-6539
• www.greenedd.org

Authorization for Use of Disclosure of Protected Health & Confidential Information

Re: _____ **DOB: _____**
(Printed Name of Individual)

I hereby authorize the following person or organization to exchange/give/receive/share/disclose/re-disclose specific health information regarding service delivery for the purpose of securing, coordinating, and /or providing services for the above named person.

Greene County Board of Developmental Disabilities
(Name of Person/Organization)

To the following person or organization

Opportunities for Ohioans with Disabilities (Name of Person /Organization)_____

Name of School_____

List information being requested in detail:

Work Observations, Assessments, Interest Inventories

For the purpose of: Transition Planning

Unless earlier revoked, this authorization will expire on the 365th day of the signing or as otherwise specified _____ days.

(I may revoke this Authorization at any time by notifying the releasing organization/person in writing except to the extent that the releasing organization/person has acted on the authorization).

I understand that once this authorization is acted upon, the receiving party may be under no legal obligation to maintain the confidentiality of health information and could disclose it to another party.

I understand that the provision of health care services will not be affected if I do not sign this authorization form.

This release is not valid for information regarding drug abuse, alcohol abuse, and psychotherapy notes regarding sexually transmitted diseases.

A copy of this release has been offered to the individual, parent/guardian _____
(Signature)

Signature of Individual: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____