



## 2009 Computer Camp Application Form

The information provided to PROVAIL through this application will not be shared with any third parties or used for any purposes other than Computer Camp unless otherwise approved by the appropriate parent or guardian. Space in camp is limited and unfortunately completion of an application does not guarantee acceptance into camp. Please complete the form as thoroughly as possible and we will contact you by no later than May 8<sup>th</sup> to inform you of our decision. If you have questions please call Gabriel [206-826-1050] or Andrea [206-826-1022]

### General Information

Client Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

Applicant's perception of their ability to understand English:      Adequate      Limited      No English      Second language? \_\_\_\_\_  
Is the applicant a recent arrival in the United States? \_\_\_\_\_  
Number of individuals in the applicant's household: \_\_\_\_\_

### Referral Information (please give detail)

Referred by: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Phone or other contact info: \_\_\_\_\_

### Affirmative Action Voluntary Information

To assist us in complying with requirements regarding government recordkeeping, reporting and other legal obligations, we ask that you complete this application data survey. It is *NOT* required that you fill this section out to apply for the camp. It is considered confidential and will have no bearing on whether you are ultimately invited to join this year's camp session.

Please check gender

- Male  
 Female

Please check one or more of these groups that best describes you.

- Hispanic or Latino       White       Black or African American  
 Native Hawaiian or Other Pacific Islander       Asian  
 American Indian or Alaska Native       Two or more races

The current median household incomes for Washington State as reported by the U.S. Census Bureau are:

2-person families	\$58,584
3-person families	\$66,252
4-person families	\$75,140
5-person families	\$68,562
6-person families	\$62,484
7-or more person families	\$61,212

Is the applicant's total household income:

- Over 80% of the median for the size of the household.  
 51-80% of the median.  
 31-50% of the median.  
 Less than 30% of the median.

## Availability

A parent or primary care giver *must* be able to participate on the first morning of camp for a minimum of **1 hour** and the final afternoon of camp for at least **1 to 2 hours**. Can this commitment be met? And if so, by whom? \_\_\_\_\_

The typical camp day consists of a 30 minute morning greeting time, a morning session, a 1 hour lunch and social time, and an afternoon session.

Can a support person (Family, Primary Care Giver, Therapist, S.E. Teacher) participate more extensively during the computer camp? If yes, please give as much detail as you can of whom and when that might be so that we can best allocate our time and volunteers. \_\_\_\_\_

## Goals/ Expectations

Please list as many of the parents goals for camp as you can with detail, and as many of the camper's goals as they can come up with.

Parent Goals		Camper Goals	
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

List activities/ objects/ hobbies/ & people the child finds motivating or interesting & time spent on them.

Area of interest:	Hours per Month	✓ If no longer able to access
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments about social behavior: \_\_\_\_\_

## Medical/ Health Information

Primary Diagnosis	Other Condition (check off Primary or other)	Onset Dates	Specifics/ Comments
<input type="checkbox"/>	<input type="checkbox"/>		Amyotrophic Lateral Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>		Traumatic Brain Injury
<input type="checkbox"/>	<input type="checkbox"/>		Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>		Spinal Cord Injury
<input type="checkbox"/>	<input type="checkbox"/>		Stroke
<input type="checkbox"/>	<input type="checkbox"/>		Cerebral Palsy
<input type="checkbox"/>	<input type="checkbox"/>		Developmental Delay
<input type="checkbox"/>	<input type="checkbox"/>		Autism
<input type="checkbox"/>	<input type="checkbox"/>		Emotional/ Behavioral Disability
<input type="checkbox"/>	<input type="checkbox"/>		Learning Disability

		Cognitive Impairment	_____	_____
		Hearing Impairment	_____	_____
		Sensory Impairment	_____	_____
		Visual Impairment	_____	_____
		Seizures	_____	_____
		Other	_____	_____

Anticipated Course of Condition    Stable:     Improving:     Deteriorating:     Fluctuating:

General Health Condition    Excellent:     Good:     Fair:     Poor:

Medications: \_\_\_\_\_

List any joint dislocations, deformities, other orthopedic problems, and past or pending surgeries:  
 \_\_\_\_\_  
 \_\_\_\_\_

## Sensory/ Perceptual Abilities

### Vision

(Yes / No)

Visual deficits?	_____	Comments: _____
Wear glasses or corrective lenses?	_____	Comments: _____
Perceptual deficits?	_____	Comments: _____
Lighting affect vision?	_____	Comments: _____
Can fixate vision on stationary object?	_____	Comments: _____
Can follow a moving object?	_____	Comments: _____
Can look right/left without moving head?	_____	Comments: _____
Preference for placement of objects?	_____	Where in visual field? _____
Responds better to colors	_____	If yes, which colors? _____

### Hearing

Known hearing loss?	_____	If yes, include audiology results.
Uses assisted listening device?	_____	Comments: _____
Reacts to sounds?	_____	Comments: _____
Understands speech?	_____	Comments: _____

### Sensation

Full Sensation	_____	Comments: _____
Partial Sensation	_____	Comments: _____
Tactile	_____	Comments: _____
Pressure	_____	Comments: _____
Touch	_____	Comments: _____
Pain	_____	Comments: _____

Pain rating (1-10 based on report): \_\_\_\_\_    Location on body: \_\_\_\_\_

## Communication Skills

\*Check off all methods used to communicate:

Speech:  Single Words:  Phrases:  Whole Sentences:  How much?  %  
*Intelligibility* To All Listeners:  Only to Familiar Listeners:

Gestures:  Eye Gaze:  Facial Expressions:  Vocalization:

Sign Language:   
 If yes, Type- ASL:  SEE:  Other:

Number of signs used: \_\_\_\_\_

List 5 most commonly used signs: \_\_\_\_\_

Pointing:  If yes, How? Finger:  Foot:  Eye Gaze:  Other:

Handwriting:  Drawing:  Typing:

Communication Board/ Notebook:  If yes, Syms Used: Pictures:  Words:  Letters:   
 Number of symbols used: \_\_\_\_\_ Approximate size of symbols: \_\_\_\_\_

Object Communication:  If so list objects used: \_\_\_\_\_

Electronic Communication Device:  If yes, what type: \_\_\_\_\_

Symbols Used: Pictures:  Words:  Letters:  No. of Symbols: \_\_\_\_\_

How long has this device been used? \_\_\_\_\_

Is this successful/ How successful has it been? \_\_\_\_\_

What is the student's means of indicating "YES": \_\_\_\_\_ "NO": \_\_\_\_\_

Can the student spell? \_\_\_\_\_ If "yes", approx. grade level: \_\_\_\_\_

Is communication spontaneous? \_\_\_\_\_

## Social Interaction, Learning and Behavior

Check off the one that best describes level of Alertness:

No interest in surroundings:  Sometimes observant; sometimes sees humor in situations:   
 Little interest in surroundings:  Very alert; observant; sees humor in situations:

Check off the one that best describes his/ her social play:

Unoccupied behavior  Onlooker behavior  Solitary independent play   
 Plays among others; little interaction  Interaction with other peers

Can he/ she:

Sit and concentrate on a task for appropriate amount of time? \_\_\_\_\_

Concentrate within a distracting environment? \_\_\_\_\_

Classify different objects into categories? \_\_\_\_\_

Carry out tasks of 2 or more steps? \_\_\_\_\_

Know his/ her actions can cause something else to happen? \_\_\_\_\_

Make choices when 2 objects or activities are presented? \_\_\_\_\_

Follow directions or commands given? \_\_\_\_\_

## Motor Skills

Does the client have motor control of the following?

Eyes	<input type="checkbox"/>	Mouth	<input type="checkbox"/>	Neck/ Head	<input type="checkbox"/>
Trunk	<input type="checkbox"/>	Right Arm	<input type="checkbox"/>	Left Arm	<input type="checkbox"/>
Right Hand/ Wrist	<input type="checkbox"/>	Left Hand/ Wrist	<input type="checkbox"/>	Right Leg	<input type="checkbox"/>
Left Leg	<input type="checkbox"/>	Right Foot/ Ankle	<input type="checkbox"/>	Left Foot/ Ankle	<input type="checkbox"/>

Which part of the body is best controlled? \_\_\_\_\_

Are there any positions or supports that help control movement? \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Check off all capabilities below (and dominant side when applicable):

Write with Pen or Pencil	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>	Point with a finger	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>
Type with one digit	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>	Type with more than 1 digit	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>
Grasp/ Release object	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>	Hold Objects	Right	<input type="checkbox"/>	Left	<input type="checkbox"/>
Use both hands for a 2 handed activity		<input type="checkbox"/>	Type with head or mouth stick	<input type="checkbox"/>					
Reach capabilities:	Forward	<input type="checkbox"/>	Sideways	<input type="checkbox"/>	Backwards	<input type="checkbox"/>			
Lift capabilities:	5 lbs.	<input type="checkbox"/>	10 to 15 lbs.	<input type="checkbox"/>	20 to 25 lbs.	<input type="checkbox"/>			

Problems that may interfere with motor function:

Poor Coordination or Balance	<input type="checkbox"/>	Endurance/ Fatigue	<input type="checkbox"/>	High Tone	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	Joint Contractures	<input type="checkbox"/>
				Low Tone	<input type="checkbox"/>

## Mobility/ Positioning

Check all that apply:

Sits independently in regular chair	<input type="checkbox"/>	Unable to sit upright	<input type="checkbox"/>	Walks with assistance	<input type="checkbox"/>
Sits at edge of seat without support	<input type="checkbox"/>	Walks independently	<input type="checkbox"/>	Depends on mobility equipment	<input type="checkbox"/>
Sits in wheelchair with support	<input type="checkbox"/>	If yes, elaborate:	_____		

Uses Manual Wheelchair  If yes, used where? \_\_\_\_\_

How Propelled: Hands  Feet  Assisted/ Dependent

Accessories (e.g., Laptray): \_\_\_\_\_

Problems with Wheelchair: \_\_\_\_\_

Uses Power Wheelchair  If yes, used where? \_\_\_\_\_

Controlled by: Joystick  Sip & Puff  Chin Switch  Switch Array

Other: \_\_\_\_\_

Control Site: Hand  Head  Foot  Other: \_\_\_\_\_

Accessories (e.g., Laptray): \_\_\_\_\_

Problems with Wheelchair: \_\_\_\_\_

Is there a history of pressure sores? \_\_\_\_\_ If yes, currently? \_\_\_\_\_

## Computer Access Interests, History & Skills

Has the student ever used a computer before? \_\_\_\_\_ (If not, proceed to page 7)

When last used? As a child  teen ager  In the last 2 years  In the last 6 months

Where? Home  School  Work  In the Community

On a power chair  Manual chair  In bed

Other: \_\_\_\_\_

For how long? Less than six months  1 year  More than 2 years  More than 5 years

What type of computer? PC  Mac  Desktop  Laptop  Tablet

Other: \_\_\_\_\_

Which operating systems does the client have experience with?

Windows 95 <input type="checkbox"/>	Windows ME <input type="checkbox"/>	Windows XP Home <input type="checkbox"/>	Linux <input type="checkbox"/>
Windows NT <input type="checkbox"/>	Windows 2000 <input type="checkbox"/>	Windows XP Pro <input type="checkbox"/>	MAC OS 9 <input type="checkbox"/>
Windows 98 <input type="checkbox"/>	Windows CE <input type="checkbox"/>	Windows Vista <input type="checkbox"/>	MAC OS X <input type="checkbox"/>

What specific problems has the client encountered when accessing a computer? \_\_\_\_\_

Computer access aids the client has used:

Screen Reader <input type="checkbox"/>	Switch Input <input type="checkbox"/>	Trackball <input type="checkbox"/>	Enlarged Screen Elements <input type="checkbox"/>
Text Reader <input type="checkbox"/>	Word Prediction <input type="checkbox"/>	Joystick <input type="checkbox"/>	High Contrast Display <input type="checkbox"/>
Screen Magnifier <input type="checkbox"/>	Macros <input type="checkbox"/>	Specialized Mice <input type="checkbox"/>	Switch Scanning Software <input type="checkbox"/>
Large Monitor <input type="checkbox"/>	Keyboard Tray <input type="checkbox"/>	"MouseKeys" <input type="checkbox"/>	Oversized Keyboards <input type="checkbox"/>
Morse Code Input <input type="checkbox"/>	Ergonomic Chair <input type="checkbox"/>	"StickyKeys" <input type="checkbox"/>	Low Profile Keyboards <input type="checkbox"/>
Voice Recognition <input type="checkbox"/>	Specialized Table <input type="checkbox"/>	"FilterKeys" <input type="checkbox"/>	Enlarged Keyboard <input type="checkbox"/>
"SoundSentry" <input type="checkbox"/>	Comm. Software <input type="checkbox"/>	"ToggleKeys" <input type="checkbox"/>	Keyboard with Keyguard <input type="checkbox"/>
"ShowSounds" <input type="checkbox"/>	Customized Cursors <input type="checkbox"/>	Mouse "ClickLock" <input type="checkbox"/>	Mouse "Snap To" <input type="checkbox"/>

Specifics of access technology used:

Name	Version number	How long you have used it	Currently have access to it?	Repairs or Mods. needed?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other notes on access aids: \_\_\_\_\_

If the client owns any computer equipment describe in as much detail as possible here:

**What does the client hope to accomplish with computer access?**

E-mail	<input type="checkbox"/>	Instant Messaging	<input type="checkbox"/>	General Employment	<input type="checkbox"/>	Database Access	<input type="checkbox"/>
News Groups	<input type="checkbox"/>	Downloading Software	<input type="checkbox"/>	School Work	<input type="checkbox"/>	Photography	<input type="checkbox"/>
Surfing the Internet	<input type="checkbox"/>	Personal Finances	<input type="checkbox"/>	Music	<input type="checkbox"/>	Augmentative Comm.	<input type="checkbox"/>
Online Shopping	<input type="checkbox"/>	Art Programs	<input type="checkbox"/>	Video	<input type="checkbox"/>	Auction (Ebay)	<input type="checkbox"/>
Social Networking	<input type="checkbox"/>	Educational Programs	<input type="checkbox"/>	Word Processing	<input type="checkbox"/>	Telephone Access	<input type="checkbox"/>

Other goals: \_\_\_\_\_

Are there care givers, family members or friends willing to invest time in access assistance & training?

Name	Relationship	Contact Number

**What are the perceived barriers you see or have had to accessing this type of camp?**

- No Computer Camps have been offered that I know of.
- The cost of such training camps has been prohibitive to our attending.
- The Computer Camps that we have heard about have been too distant to be practical for us to attend.
- I have heard about such camps in general but could not obtain adequate information about them.
- I did not realize or believe my child could benefit from this type of camp.
- Computer Camps have been scheduled too early for us to attend.
- Transportation complications have made it too difficult for us to manage coming to such a camp.
- Personal care needs such as: medications, toileting & feeding have been too complicated to be feasible.
- Other barriers:

Evaluator's Comments: