SUMMER CAMP

FOR KIDS WITH SPECIAL NEEDS

The Ingeborg A. Biondo Memorial Foundation

The Ingeborg A. Biondo Memorial Foundation is a not for profit organization devoted to providing assistance to challenged individuals in the tristate area. The Foundation was created in 1986 as a memorial to Ingeborg A. Biondo who was actively involved in the lives of young children, particularly those in need. The Foundation provides summer camperships through local camps in the tristate area. These programs provide a fun, educational and rewarding experience for kids with special needs.

If you are interested in applying for funding from the Biondo Foundation for a summer camp experience for your child, please complete the application to determine your child's eligibility for this unique program. Applications will be accepted on a first come, first considered basis. The Board of Directors for the Foundation reserves the right to limit the number of applicants and to select all campers based solely on its own criteria.

For more information, please contact Nicole Armstrong via phone at (570) 202-0119, email at info@biondofoundation.org or visit us at www.biondofoundation.org.

APPLICATION DEADLINE: May 15, 2020

Please note that admission is granted on a first come, first served basis.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

1. There is a $25 application fee per family. This fee will be refunded if your child is not granted a campership.
2. Application MUST be accompanied by a copy of child's IEP cover page and signature page EVERY year. If you are applying for Camp Nejeda you must provide a doctor's diagnosis note. Additional documentation may berequired. If you fail to submit the required documentation your child's application will not be considered.
3. This application is for funding purposes only. Camps will require completion of their own applications.
4. A maximum of $1,000 for day camp programs and $1,500 for overnight/residential camp program is allocated for each child's camping experience.
5. The parent/guardian AND the child must visit the camp and meet with a camp representative prior to the camping experience to ensure the camp is a good fit for your child.
6. The parent/guardian is required to sign a release of liability PRIOR to the camping experience and are encouraged to sign a Publicity Permission form (included on the application).
7. To obtain specific information about the camping programs offered by the camp in which you interested, including dates of camp sessions, you must contact the camp directly. The participating camps are:

Blue Mountain Day Camp	Stillwater, NJ	www.fairviewlakeymca.org
Camp Lee Mar	Lackawaxen, PA	www.leemar.com
Camp Merry Heart	Hackettstown, NJ	www.eastersealsnj.org/camp
Camp Nejeda	Stillwater, NJ	www.campnejeda.org
Camp Shohola for Boys	Greeley, PA	www.shohola.com
Camp Speers-Eljabar YMCA	Dingmans Ferry, PA	campspeersymca.org
Camp Watonka	Hawley, PA	www.watonka.com
Country Ark Farms	Milford, PA	www.countryarkfarm.org
Dragonfly Forest	Dingmans Ferry, PA	www.dragonflyforest.org
Equine Tranquility Wellness Center	Andover, NJ	www.equinetranquility.org
GAIT	Milford, PA	www.gaittrc.org
Morning Star Farm	Newton, NJ	www.mstarfarm.com
PEEC	Dingmans Ferry, PA	www.peec.org

8. Campership funds must be used at one of the above camps.
9. The Foundation does not provide transportation of any kind.
10. Completed application, application fee and copies of IEP pages and/or doctor's diagnosis must be returned either via mail or email to:

Ingeborg A. Biondo Memorial Foundation
PO Box 231
Milford, PA 18337
•
info@biondofoundation.org

INGEBORG A. BIONDO MEMORIAL FOUNDATION CAMPERSHIPS

Please complete both sides of this page and return to the Foundation. Completed applications can be mailed to: Ingeborg A. Biondo Memorial Foundation ▪ P.O. Box 231 ▪ Milford, PA 18337.

CHILD'S NAME_____ AGE _____

PARENT'S NAME(S) _____

PHONE (H) _____ PHONE (C) _____

ADDRESS _____

Email_____

County_____Pike_____Sussex_____Western Orange

Physician's diagnosis of child _____

Child's Physician (Name & Address) _____

****** PLEASE PROVIDE A COPY OF CHILD'S IEP COVER & SIGNATURE PAGES.
CAMP NEJEDA APPLICATIONS REQUIRE PROOF OF DIAGNOSIS FROM YOUR PHYSICIAN.
THIS IS REQUIRED AND WITHOUT IT YOUR CHILD'S APPLICATION WILL NOT BE CONSIDERED ******

Please check all that apply to your child:

____Allergies ____Medication ____Diet Restrictions ____Seizures ___Non-verbal ___Wheelchair

____Restriction on camp activities ___Wanders off ___Physical/verbal outbursts

If you checked anything above please describe_____

_____

Please describe the amount of assistance your child requires, if any, with the following: meals, ambulation, work/participation, toileting needs. Please also include any information you feel would be helpful:

_____

_____

Does your child display challenging behaviors at times?_____Yes ___ No

If so please describe the behavior, what is likely to trigger them and what helps him/her to overcome them.

_____

_____

_____

Does your child receive TSS support?____Yes ___No If yes, how many hours per week? _____

Camp Choice _____

Number of weeks your child would like to attend: _____

PUBLICITY PERMISSION

The Ingeborg A. Biondo Memorial Foundation encourages parents/guardians to give permission for including their children in publicity materials. Our goal is to inform parents/guardians of every eligible child about the foundation's camperships. Granting permission for publicity is not required for your child to attend camp but it is appreciated.

I give permission to the Ingeborg A. Biondo Memorial Foundation to use pictures, stories, tapes, documentaries, articles or other media pertaining to_____(child's name) experience at_____(camp).

I understand these materials may be used with discretion for the purpose of fundraising and public education conforming with the stated purposes of the Ingeborg A. Biondo memorial foundation.

_____ _____

Signature of Parent or Guardian Date

THE FOLLOWING RELEASES MUST BE SIGNED BY THE PARENT OR GUARDIAN OF EACH CHILD ATTENDING CAMP.

LIABILITY RELEASE

I hereby give permission for_____to participate in camping programs sponsored by the Ingeborg A. Biondo Memorial Foundation ("the Foundation"). In so granting my permission I agree to indemnify, save and hold the said Ingeborg A. Biondo Memorial Foundation free and harmless from any liability arising out of or in any way connected with my child's participation at_____(camp).

In releasing the Foundation from any liability, I acknowledge that the Foundation's role is merely one of sponsorship and not implementation of the program for which I am granting permission for my child to participate. I further understand that the Foundation sponsorship is not to be interpreted by me, either directly or indirectly, as an endorsement that the particular program under consideration meets my child's specific needs and that I have made the decision for my child to participate based upon my own inspection, investigation, and examination and in consultation with the camp itself relative to the program to be offered.

_____ _____

Signature of Parent or Guardian Date

Sharing information provided with this application with camp staff will help to ensure a successful camp experience for your child. Please sign the following in order for us to release the information provided to the camp of your choice.

AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL INFORMATION

Child's name:_____ D.O.B. _____

I hereby authorize Ingeborg A. Biondo Memorial Foundation to exchange written or verbal information with:

Camp_____ Address _____

For the purpose of consultation on the above named child's medical needs. If for other reason list here:

_____

The information to be released is:

( ) General Information (contact info, school district, days attending school, etc) ( ) Individual Education Program

( ) Medical Report (evals & summaries only, no charting needed) ( ) Evaluation Report ( ) Psychological Report

( ) Speech Report ( ) Educational Report ( ) OT Report ( ) PT Report ( ) Vision Report

( ) Audiological Report ( ) Behavior Plan ( ) Other (specify) _____

HIV related information contained in the parts of the record indicated above will not be released through this consent. A separate consent is required in order to release HIV related information.

I have been told that in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above and will be effective for one year after the date of my signature, unless specified below. I also understand that I may revoke this Authorization in writing except to the extent that action has been taken in reliance thereon. Refusal to sign this authorization will not impact educational programming. I also understand and agree that the foundation may utilize qualified professionals who are not representatives, agents and/or employees of the Foundation to review all applications to ensure accuracy and qualifications. I further understand that the Foundation cannot be held liable for any opinions rendered by such qualified professionals in aid of the application process.

This consent shall be in effect from_____until _____

_____ _____ _____

Signature of Parent/Guardian Authority/Relationship Date