

Courage Center  
**CAMPS**  
2010

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**Application**



# RESIDENT CAMP APPLICATION

Return to:  
Courage Center Camps  
8046 83rd St. NW  
Maple Lake, MN 55358  
FAX: 320.963.3698 (all faxed applications must also be mailed)



|                     |       |
|---------------------|-------|
| For office use only |       |
| ___ Application fee | _____ |
| ___ Camp Wise entry | _____ |
| ___ Confirmation    | _____ |

ALL RESIDENT CAMP APPLICANTS FILL OUT THIS PAGE      PLEASE PRINT      RETURN PAGES A-D and F-J

**COURAGE CAMP(S) YOU ARE APPLYING FOR:** (See pages 3-10)

|                             |                  |             |
|-----------------------------|------------------|-------------|
| CAMP COURAGE-Lakeside _____ | Session(s) _____ | dates _____ |
| CAMP COURAGE-Woodland _____ | Session(s) _____ | dates _____ |
| CAMP COURAGE NORTH _____    | Session(s) _____ | dates _____ |

**GENERAL INFORMATION** Has applicant attended Courage Center Camps before  yes  no T-shirt size \_\_\_\_\_

**How did you hear about Courage Camps?**  Web site \_\_\_\_\_  Friend  Brochure  
 Newspaper  Other \_\_\_\_\_

Name of applicant - last, first, middle \_\_\_\_\_ age \_\_\_\_\_ date of birth (mm/dd/yy) \_\_\_\_\_  
 ( \_\_\_\_\_ )

Home address \_\_\_\_\_ Number & Street or Route \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Primary Disability \_\_\_\_\_ Secondary Disabilities \_\_\_\_\_

**EMERGENCY CONTACT other than parent/guardian**

Name \_\_\_\_\_ ( \_\_\_\_\_ ) phone with area code \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

**PARENT/FOSTER PARENT/GUARDIAN INFORMATION** (If under 18) Is applicant a foster child?  yes  no

1. Full name of parent/guardian \_\_\_\_\_ occupation \_\_\_\_\_  
 Email \_\_\_\_\_ ( \_\_\_\_\_ ) work phone with area code \_\_\_\_\_ ( \_\_\_\_\_ ) cell phone with area code \_\_\_\_\_

2. Full name of parent/guardian \_\_\_\_\_ occupation \_\_\_\_\_  
 Email \_\_\_\_\_ ( \_\_\_\_\_ ) work phone with area code \_\_\_\_\_ ( \_\_\_\_\_ ) cell phone with area code \_\_\_\_\_

Please explain any special custodial information \_\_\_\_\_

Who will bring your child to camp? \_\_\_\_\_

**CABIN ROOMMATE REQUEST**

No roommate preference  
 Applicant would like to room with \_\_\_\_\_  
 (requested roommate must also list applicant or we cannot honor the request)

Note: Courage Center Camps reserves the right for final placement based on capacity.

**PERSONAL CARE ASSISTANCE**

Assistance level : \_\_\_\_\_Independent \_\_\_\_\_Some assistance \_\_\_\_\_Total assistance

Applicant requires assistance with:  
 washing face and hands  brushing teeth  combing hair  shaving  menstrual care  showering  dressing

Does Applicant wear dentures?  Yes  No  
 Does the applicant have Orthodontics?  Yes  No Retainers  Yes  No

Further information or instructions: \_\_\_\_\_

Name \_\_\_\_\_

### MOBILITY/AMBULATION

Does Applicant use a Wheelchair?  Yes  No  Long distances only  Manual  Electric

Does the Applicant require assistance with transferring?  Yes  No Please indicate type of transfer used at home: \_\_\_\_\_

Can applicant support weight in transferring?  Yes  No

Does the Applicant require assistance with walking?  Yes  No  Support from another person  Cane  Crutches  Walker

Does applicant wear/use?  Orthotics  Prosthesis  Braces/splints

Management of above items?  Independent  Dependent

Does Applicant have daily range of motion exercises?  Yes  No

Further information or instructions \_\_\_\_\_  
\_\_\_\_\_

### EATING

Applicant's assistance level:  Independent  Some assistance  Total assistance

**Special diet**  Yes  No, describe: \_\_\_\_\_

Difficulty with:  swallowing  chewing  drinking

Applicant requires:  special utensils (please bring)  chopped/pureed food

dietary supplement (please bring)  straw  feeding tube

Further information or instructions \_\_\_\_\_  
\_\_\_\_\_

### SLEEPING

Does Applicant require repositioning during sleeping hours?  Yes  No If yes, how often: \_\_\_\_\_

Uses bed rails?  Yes  No

Further information or instructions \_\_\_\_\_  
\_\_\_\_\_

### URINARY/BOWEL CARE

Assistance required by Applicant:  Independent  Needs reminders  Needs assistance  Total assistance

**Urinary:**  Continent  Incontinent

Catheter  Yes  No Size \_\_\_\_\_  Straight  Foley

Continue after discharge  Yes  No

Time d/c'd: \_\_\_\_\_ Date changed: \_\_\_\_\_

Ostomy: Brand \_\_\_\_\_ Size \_\_\_\_\_

Sterile technique required?  Yes  No

**Bowel:**  Continent  Incontinent  Prone to constipation

Ostomy: Brand \_\_\_\_\_ Size \_\_\_\_\_

Powder  Ointment/ Cream  Bowel program

Further information or instructions \_\_\_\_\_  
\_\_\_\_\_

### ORIENTATION/BEHAVIOR (check all that apply to Applicant)

**Orientation:**  Oriented to person, place and time  Minor or periodic forgetfulness

Partial disorientation  Total Disorientation

Non responsive

**Behavior:**  No behavior concerns  Minor problem, easily redirected

Moderate problem- redirection needed  Verbally abusive

Physically aggressive  Sexually inappropriate

Nocturnal disturbances  Behavior management program in place

Name of behavior specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional Information (attach a separate sheet if necessary) \_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

**COMMUNICATION** Please indicate method(s) of communication used by the applicant.

Yes No

- Able to talk?  
  Uses a communication device? Type \_\_\_\_\_  
  Understands what is said?

Yes No

- Able to read?  
  Able to write?  
  Able to communicate pain?

**SPEECH AND LANGUAGE** Complete this section **if** the applicant has a **speech or language impairment**.

Briefly describe the applicant's communication disorder.

Is the applicant receiving speech/language help?  Yes  No If yes, how long? \_\_\_\_\_  
If yes, give name of current therapist or persons who have been consulted:

Name address

( )

City/state/zip

phone after June 1 with area code

Name address

( )

City/state/zip

phone after June 1 with area code

**Speech:** Check any of the following statements that apply to the applicant:

- Cannot be understood  Has voice problems  Cannot say some sounds clearly  
 Stutters  Has a cleft palate

**Language:** Check any of the following that apply to the applicant:

- Listening: has difficulty understanding the communication of other people  
 Speaking: has difficulty expressing ideas vocally  
 Grammar: has difficulty understanding and using syntax structures  
 Writing: has difficulty expressing thoughts in written form  
 Vocabulary: has difficulty using and understanding new words  
 Reading: has difficulty comprehending written messages  
 Receptive language: has difficulty comprehending both spoken and written language  
 Expressive language: has difficulty in using both spoken and written language to communicate with others

**DEAF OR HARD OF HEARING** Complete this section **if** the applicant is **deaf or hard of hearing**.

Check **all** of the following statements that apply to the applicant:

- Uses hearing aid: part time/full time (circle one)

Model & Serial # of hearing aid \_\_\_\_\_

- Uses speech  Lip reads  
 Speaks well  Uses sign language  
 Understood by family members  Can hear telephone conversations

Amount of hearing loss  Total (no usable hearing)  Severe (little usable hearing)  Hard of hearing (some hearing with hearing aid)

Cause of hearing loss \_\_\_\_\_

How long has the applicant had the hearing loss? \_\_\_\_\_

Name \_\_\_\_\_

**CONSENT FORM THIS SECTION MUST BE SIGNED either by applicant OR parent/guardian (If applicant is under age 18)**

The applicant/guardian has read and understands all the information in this application and acknowledges that a wide variety of activities are conducted at Courage Camps and gives permission for the above camper to participate in these activities assuming all ordinary risks normally inherent to the nature of the activities. It is also understood that the camper may be transported and be out of camp while on various field trips or camping trips.

That in consideration of **Courage Center** allowing my use of Courage Center facilities and its locations and participation in its activities, under the terms set forth herein, I agree to hold harmless, release and discharge **Courage Center**, its owners, agents, employees, personnel, sponsors, officers, directors, representatives, assigns, members, affiliated organizations, insurers, and others acting on its behalf (hereinafter collectively referred to as "ASSOCIATES"), of and from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to **Courage Center's** and/or its ASSOCIATES' ordinary negligence; and I do further agree that, except in the event of **Courage Center's** and/or its ASSOCIATES' gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against **Courage Center** and/or its ASSOCIATES as stated above in this clause, for any economic and/or non-economic losses due to bodily injury, death, property damage sustained by me and/or my minor children and/or legal wards, if any, in relation to the premises and/or operations of **Courage Center**.

To provide you with services in Courage Camps, Courage Center may need to use and disclose health-related information about you. **I AUTHORIZE Courage Center and Courage Camps to use and disclose my/my child's name and disability information as follows: my/my child's contact information, information about my/my child's physical health, mental health or other services, and payment for services.**

**I also authorize Courage Center to:**

- Use information about me/my child to provide services to me/my child and to communicate across departments with Courage Center to coordinate my/my child's services.
- Disclose information to insurance companies, or other government or private payers, in order for Courage Center to obtain payment for its services.
- Use and disclose information about me/my child, as necessary, for the purpose of Courage Center operations, such as case management, quality assurance and staff training.
- Disclose:
  - a. Name, address, telephone number, e-mail address.
  - b. To include information in the camp roster to be given to campers, staff, and program volunteers.
  - c. To assist in communication regarding camp, Courage Center, and community events.
- I/my child will be identified by name as a normal part of camp life.

**I understand that:**

- This authorization must be filled out completely to be valid. A copy is as valid as the original.
- Courage Center will not refuse to provide services to me based on my refusal to authorize the use or disclosure of my/my child's personal health information for a purpose unrelated to those services.
- I may revoke this authorization at any time by notifying Courage Center in writing. If I do, it won't affect any actions Courage Center took in reliance on this authorization before I revoked it.
- Once information is released to a third party according to this authorization, Courage Center cannot prevent its re-disclosure.
- This authorization does not limit the ability of Courage Center to use or disclose my/my child's health information as otherwise permitted by state or federal law.
- This authorization allows the use of my/my child's name, address, videos, photographs, or comments in publicizing the work of Courage Camps, Courage Center, or the American Camp Association.

**By signing below, I acknowledge that I have read, understood, and consent to the terms of the information provided above as well as accept and voluntarily participate, knowing the inherent risk due to the nature of the activities. I have crossed out any of the above statements which I do not agree or consent.**

Signature of camper OR parent/guardian OR camper's personal representative \_\_\_\_\_ Date \_\_\_\_\_

If signed by camper's personal representative, please PRINT the name and describe the relationship to consumer:

Printed Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_

SEND COMPLETED APPLICATION AND FEES TO: Camp Courage, 8046 83<sup>rd</sup> St. NW, Maple Lake, MN 55358  
OR FAX: 320.963.3698 (note: all faxed applications must also be mailed)

Courage Center wants to provide the best care possible for all our clients. Our ability to do this depends on gaining support from foundations, corporations, public agencies and the United Way. We can be more successful if we can assemble and provide information about our clients.

Thank you for helping us to maintain quality care by answering the questions on this page. The information you provide will be used in a confidential manner. Your Courage Center care will not be affected by your choice to answer or not answer these questions.

1. Which category best describes your race or ethnicity?

- |   |   |
|---|---|
| <input type="checkbox"/> African                          | <input type="checkbox"/> African American, non-Latino/a |
| <input type="checkbox"/> American Indian/Alaskan Native   | <input type="checkbox"/> Asian                          |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Caucasian/White, non-Latino/a  |
| <input type="checkbox"/> Latino/a                         | <input type="checkbox"/> East Indian                    |
| <input type="checkbox"/> Bi- or Multi-Racial              | Other _____   |

2. **First**, circle the number on the left that matches how many people, including you, are in your household. **Then**, on the line directly to the right of the number you circled, check the box next to the one category that includes your household income.

| Number of persons in household | Income up to and including (A)    | Between (B)                              | Income at or above (C)            |
|--------------------------------|-----------------------------------|--|-----------------------------------|
| 1                              | <input type="checkbox"/> \$10,829 | <input type="checkbox"/> \$10,830-21,659 | <input type="checkbox"/> \$21,660 |
| 2                              | <input type="checkbox"/> \$14,569 | <input type="checkbox"/> \$14,570-29,139 | <input type="checkbox"/> \$29,140 |
| 3                              | <input type="checkbox"/> \$18,309 | <input type="checkbox"/> \$18,310-36,619 | <input type="checkbox"/> \$36,620 |
| 4                              | <input type="checkbox"/> \$22,049 | <input type="checkbox"/> \$22,050-44,099 | <input type="checkbox"/> \$44,100 |
| 5                              | <input type="checkbox"/> \$25,789 | <input type="checkbox"/> \$25,790-51,579 | <input type="checkbox"/> \$51,580 |
| 6                              | <input type="checkbox"/> \$29,529 | <input type="checkbox"/> \$29,530-59,059 | <input type="checkbox"/> \$59,060 |
| 7                              | <input type="checkbox"/> \$33,269 | <input type="checkbox"/> \$33,270-66,539 | <input type="checkbox"/> \$66,540 |
| 8                              | <input type="checkbox"/> \$37,009 | <input type="checkbox"/> \$37,010-74,019 | <input type="checkbox"/> \$74,020 |
| 9                              | <input type="checkbox"/> \$40,749 | <input type="checkbox"/> \$40,750-77,759 | <input type="checkbox"/> \$77,760 |

3. What language do you feel most comfortable speaking with our staff? \_\_\_\_\_

# CAMPER HEALTH HISTORY FORM

Return this form to:  
Courage Center Camps  
8046 83<sup>rd</sup> St. NW  
Maple Lake, MN 55358  
FAX: 320.963.3698



COURAGE CENTER CAMPS

Camp Courage  
Maple Lake, MN  
320.963.3121

Camp Courage North  
Lake George, MN  
888.276.3631

## CAMPER/CAREGIVER:

- Having adequate information about applicants is crucial to our ability to provide a supportive environment. We rely on you to tell us what we need to know about applicants.
- Form must be completed and signed by a custodial parent/guardian.
- We encourage you to **keep a copy** of the completed form; notify our office of changes in writing.
- **Applicants with seizures, gastrostomy (feeding tubes), respiratory concerns, Intrathecal baclofen pump or diabetes will be asked to complete additional forms that our office will provide.**
- Questions? Call the numbers above.

## GENERAL INFORMATION

Name of applicant – Last, First, Middle                      Age                      Sex                      Date of Birth (mm/dd/yy)

Home address                      Number & Street or Route                      City/State/Zip

## EMERGENCY CONTACT *Please attach extra sheet if additional space is needed.*

### Primary contact (Parent or guardian/caregiver to be contacted in case of illness or injury)

Home Phone Number                      Alternate Phone Number

Contact's home address                      Number & Street or Route                      City/State/Zip

### Secondary contact (if parent or guardian/caregiver cannot be reached)

Home Phone Number                      Alternate Phone Number

Contact's home address                      Number & Street or Route                      City/State/Zip

## PRIMARY CARE PHYSICIAN INFORMATION

Primary care clinic's name                      Primary care physician's name

Clinic Phone number

Clinic address                      Number & Street or Route                      City/State/Zip

## SPECIALIST PHYSICIAN INFORMATION *(if you have additional specialists please attach a separate piece of paper with their contact information)*

Specialist clinic name                      Specialist physician's name

Clinic Phone number

Clinic address                      Number & Street or Route                      City/State/Zip

Name \_\_\_\_\_

**INSURANCE INFORMATION** Fill in Insurance/Medical Assistance information below. **Attach a copy of the front AND back of your Insurance and/or Medical Assistance card.**

Insurance company name (or write Medical Assistance) Insurance Company's Phone number

Policy number Group number

Social Security number Medical Assistance (MA) number

**HEALTH HISTORY** Check all that applicant is subject to

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Frequent ear infections   | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Hypertension                       |
| <input type="checkbox"/> Heart defect/disease      | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Tube Feeding                       |
| <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Decubiti/skin breakdown            |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Asthma                             |
| <input type="checkbox"/> Bleeding disorders        | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Uses Oxygen/nebulizer/tracheostomy |
| <input type="checkbox"/> Intrathecal baclofen pump | <input type="checkbox"/> MRSA/VRE           | <input type="checkbox"/> TB                                 |
| Other: _____                                       |   |   |

**Camp must be notified BEFORE the camp session starts if the camper has been diagnosed with any resistant infections (i.e. MRSA, VRE, etc.)**

Date of last Dexascan (if applicable): \_\_\_\_\_ Results: \_\_\_\_\_

**ALLERGIES/DIET/RESTRICTIONS** Please attach an extra sheet if additional space is needed.

Allergies (Please describe any food, medication, or environmental allergies and the camper's reaction):

\_\_\_\_\_  
\_\_\_\_\_

Special Diet/Dietary Restrictions (Please list and describe any special diet regimens the camper follows (i.e. diabetic diet, gluten free diet, tube feedings, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Physical restrictions (Please list any physical restrictions that may affect the camper's participation in camp activities):

\_\_\_\_\_  
\_\_\_\_\_

**CAMPER MEDICATIONS:**

Attach a CURRENT list of medications (typed if possible) that should be taken while at camp. Include the name and dose of the medications, and what time of day they are taken. Medications are passed to campers at mealtimes (breakfast, lunch, dinner) and at bedtime. Please indicate if medications need to be given at specific times outside of those times.

Medications must be sent with the camper in the ORIGINAL bottles with the camper's name clearly marked. Be sure to send a quantity sufficient for the session dates, plus extra amounts in case the original doses need to be replaced. Please do NOT send presorted pills in boxes or envelopes.

**PLEASE NOTE:** It is Courage Center Camps policy that ALL camper medications will be collected by the medical staff on Intake day. Camper medications will be distributed during the sessions at the instructed times.

**IMPORTANT  
READ THIS  
SECTION  
CAREFULLY  
AND SIGN  
BELOW**

This health history is correct and accurately reflects the health status of the camper named on this form. **I understand the camper may not attend camp if they have been exposed to a contagious disease within three weeks of the first day of the camp session. I agree to notify the Camp Director immediately if exposure occurs. I further agree to disclose any resistant infections (i.e. MRSA, VRE, etc) the camper has had diagnosed.** I authorize the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, and to order injection, anesthesia, and/or surgery for the camper named in this form in the event that the camper is unable to do so for themselves, or if the camp staff is unable to reach their parent/guardian. I understand that the information on this form may be shared with camp staff on a "need to know" basis. I understand this form may be photocopied for use outside of camp.

Signature of camper, OR signature of caregiver/guardian (if camper is under 18)

Date

*Copy this form and return the original to Courage Center Camps!*

Name \_\_\_\_\_

## Camp Fee Schedule - 2010

We want everyone to experience the joy of camp, and have financial assistance available for those campers unable to pay the full cost of a session. Below is a chart to help calculate the cost of camp if you are unable to pay the full amount. Once you determine the minimum you are asked to pay, please fill out the form on the following page and return with your application.

The 2010 camp fee schedule appears on next page.

### FINANCE INFORMATION

**APPLICATION FEE (\$45)** *Fee must accompany this completed and signed form in order for camp application to be processed.*

- My check for \$45 is enclosed  
 Charge the application fee on my VISA or MasterCard

Name on card

Card #

Expiration date

Signature

**SESSION FEE** *Courage Center Camps must receive your session fee one week prior to the first day of camp.*

*If you cannot pay all or part of the session fee, please complete the next section of this form. If you want to request a special payment plan, supplement the session fee through waived services funding, or if you have any questions regarding finances, please call Courage Camps at 763.520.0504, or toll free at 1.866.520.0504, or email us at [camping@couragecenter.org](mailto:camping@couragecenter.org).*

Fee for session applicant wants to participate in (see page I): \_\_\_\_\_

- Check     My check for \$\_\_\_\_\_ is enclosed.     Charge my Visa or MasterCard

Name on card

Card #

Expiration date

A local group is sponsoring the applicant. \_\_\_\_\_  
Name of group

The applicant receives waived services. We will need a copy of the authorization of funds for camp.

County: \_\_\_\_\_

Case worker's name: \_\_\_\_\_ Phone with area code: (     ) \_\_\_\_\_

Case # \_\_\_\_\_

Check of the following received by applicant:

TEFRA     CADI     CAC     TBI     EW     AC     MR     Medical Assistance    # \_\_\_\_\_

Name \_\_\_\_\_

### Camp Fee Schedule - 2010

1. Find your total household income in the left column **and then**
2. Find the total number of people living in your household in the center columns
3. Using the percentage of discount in your combined columns, find the cost for the session you want to attend below  
**This is your total discount.**

| HOUSEHOLD INCOME    | TOTAL NUMBER IN HOUSEHOLD |      |      |           |
|---------------------|---------------------------|------|------|-----------|
|                     | 1                         | 2    | 3    | 4 or more |
| \$0 - \$20,000      | 100%                      | 100% | 100% | 100%      |
| \$20,001 - \$30,000 | 30%                       | 50%  | 70%  | 100%      |
| \$30,001 - \$40,000 | 10%                       | 30%  | 50%  | 70%       |
| \$40,001 - \$50,000 | 0%                        | 10%  | 30%  | 50%       |
| \$50,001 - \$60,000 | 0%                        | 0%   | 10%  | 30%       |
| \$60,001 - \$70,000 | 0%                        | 0%   | 0%   | 10%       |
| \$70,001 and above  | 0%                        | 0%   | 0%   | 0%        |

% amount of camp fee eligible for campership funding

|   | FULL FEE    | DISCOUNTED FEE |             |           |           |          |
|---|-------------|----------------|-------------|-----------|-----------|----------|
| Courage Center Summer Resident Camp <b>LAKESIDE</b> | 0%          | 10%            | 30%         | 50%       | 70%       | 100%     |
| <b>Teen Session</b>                                 | \$ 750.00   | \$ 675.00      | \$ 525.00   | \$ 375.00 | \$ 225.00 | \$ 45.00 |
| <b>Adult Session 1</b>                              | \$ 750.00   | \$ 675.00      | \$ 525.00   | \$ 375.00 | \$ 225.00 | \$ 45.00 |
| <b>Adult Session 2</b>                              | \$ 750.00   | \$ 675.00      | \$ 525.00   | \$ 375.00 | \$ 225.00 | \$ 45.00 |
| <b>Adult Session 3</b>                              | \$ 750.00   | \$ 675.00      | \$ 525.00   | \$ 375.00 | \$ 225.00 | \$ 45.00 |
| Courage Center Summer Resident Camp <b>WOODLAND</b> |             |                |             |           |           |          |
| <b>Radio Camp</b>                                   | \$ 875.00   | \$ 787.50      | \$ 612.50   | \$ 437.50 | \$ 262.50 | \$ 45.00 |
| <b>Literacy</b>                                     | \$ 750.00   | \$ 675.00      | \$ 525.00   | \$ 375.00 | \$ 225.00 | \$ 45.00 |
| <b>AAC</b>  | \$ 1,200.00 | \$ 1,080.00    | \$ 840.00   | \$ 600.00 | \$ 360.00 | \$ 45.00 |
| <b>YAAAKK</b>                                       | \$ 1,200.00 | \$ 1,080.00    | \$ 840.00   | \$ 600.00 | \$ 360.00 | \$ 45.00 |
| <b>Summer Sampler</b>                               | \$ 375.00   | \$ 337.50      | \$ 262.50   | \$ 187.50 | \$ 112.50 | \$ 45.00 |
| <b>Speech/Communications</b>                        | \$ 1,800.00 | \$ 1,620.00    | \$ 1,260.00 | \$ 900.00 | \$ 540.00 | \$ 45.00 |
| <b>Youth Session</b>                                | \$ 625.00   | \$ 562.50      | \$ 437.50   | \$ 312.50 | \$ 187.50 | \$ 45.00 |
| <b>CAMP COURAGE NORTH</b><br>Summer Resident Camp   |             |                |             |           |           |          |
| Pedal, Paddle & Sail                                | \$ 625.00   | \$ 562.50      | \$ 437.50   | \$ 312.50 | \$ 187.50 | \$ 45.00 |
| Find Your True North                                | \$ 1,200.00 | \$ 1,080.00    | \$ 840.00   | \$ 600.00 | \$ 360.00 | \$ 45.00 |
| Brain Gains   | \$ 1,200.00 | \$ 1,080.00    | \$ 840.00   | \$ 600.00 | \$ 360.00 | \$ 45.00 |
| Forum on Life                                       | \$ 600.00   | \$ 540.00      | \$ 420.00   | \$ 300.00 | \$ 180.00 | \$ 45.00 |

**CAMPERSHIP** Complete this section if you are unable to pay all or part of the session fee.

Full session fee \_\_\_\_\_ Amount owed \_\_\_\_\_

Describe any special circumstances you would like Courage Camps to consider and how much you could afford: \_\_\_\_\_

\_\_\_\_\_

May Courage Camps use the applicant's name when seeking contributions for our Campership Fund?  yes  no

I certify that the above information is true and accurate. If requested, I will provide verification of income.

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Signature of camper (or parent/guardian if camper is a minor) \_\_\_\_\_ date \_\_\_\_\_

Name \_\_\_\_\_

# COMMUNICATION DISORDERS or LITERACY SESSIONS FORM

**This form must be completed only if your child is attending one of the Communication Disorders or Literacy sessions.**

Dear Parent,

In addition to completing this application, we would appreciate your cooperation in obtaining any available speech, hearing, academic, and psychological reports from your child's school. Selection of the campers for the summer program at Camp Courage is based on many factors. This supplemental information is necessary for processing of your child's application. On receipt of this information, the Camp Selection Committee will act on your child's application. The sooner we receive this information, the sooner our committee can make an acceptance determination.

**PLEASE COMPLETE AND SIGN THIS AUTHORIZATION FORM  
AND FORWARD IT TO YOUR CHILD'S SPEECH PATHOLOGIST.**

Thank you for your cooperation. Please feel free to contact our office at 763.520.0504 with questions.

**I hereby authorize** \_\_\_\_\_

School representative or speech pathologist

\_\_\_\_\_  
Name of school

to send copies of any information that contributes to the welfare of my child to Camp Courage to be used in connection with the summer therapeutic communications program.

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/state/zip

\_\_\_\_\_  
Parent or guardian's signature

**ATTENTION SPEECH PATHOLOGIST OR SCHOOL REPRESENTATIVE**

For the individual named above, please forward:

- Speech clinical history
- IEPs
- Social history (if appropriate)

Courage Center Camps  
8046 83<sup>rd</sup> St. NW  
Maple Lake, MN 55358

**You may photocopy this form or call our office for additional copies.**



Courage Camps are part of Minneapolis-based Courage Center  
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