



SummerShine ADULTS at Lutheridge

July 25 - 31, 2010

A one week residential camp for active adults with mild to moderate developmental disabilities
Please note that the program begins on Sunday at 3:30 PM and ends Saturday at 9:00 AM

Mail this completed form & either the **full fee** (see below for rate) or **minimum of \$125** deposit to address listed below:

If paid in full on or before Mar 15	If paid in full Mar 16-Apr 15	If paid in full Apr 16-May 14	If paid in full after May 15
\$443.00	\$468.00	\$478.00	\$505.00

**Lutheridge Registration—28 Spruce Drive; Arden, NC 28704
or fax to 828-684-5196**

**PLEASE READ PROGRAM DESCRIPTIONS BEFORE REGISTERING
TO ENSURE THAT YOUR CAMPER FITS SUMMERSHINE ADULTS!**

PLEASE PRINT ALL INFORMATION. This is a two-page document. Both pages are required.

Camper's Name _____ Male ___ Female ___
(Circle name used, add nickname if any)

Date of Birth _____ **Current Age** _____ (SummerShine Adults are age 25+)

This will be year number _____ at Lutheridge for this camper. (Please guess!)

Where camper resides: ___ Parent's home ___ Foster home

___ Group home (Name) _____

___ Institution (Name) _____

___ Other (Name) _____

Camper Address _____

City _____ **State** ___ **Zip** _____ **Phone where camper lives** _____

Name of person filling out application _____ **Relationship to camper** _____

Your Preferred Phone number _____ **Additional phone number** _____

Your email address _____

Person to call if camper has problems while at camp _____

Name of Parent or Guardian (if different from above) _____

Address _____ **City** _____ **State** ___ **Zip** _____

Parent/Guardian day phone _____ **evening phone** _____ **cell phone** _____

Roommate Request _____

Please list no more than ONE. Each roommate must list the other on their registration form.

Camper's Home Church: _____

City & State: _____ **Pastor:** _____

(If the camper is not affiliated with a church, simply write NONE)

The information on the next page must be complete in order for this registration form may be processed. Thank you.

For Office Use Only

Date Received _____ Fee _____ Amt Rcvd _____

Pmt Type _____ Sch _____ Bal Due _____

SSAdult ~ Camper's Name: _____ (Please Print)

PLEASE FILL THIS OUT AS COMPLETELY AND ACCURATELY AS POSSIBLE. THANK YOU!

SELF CARE / MOBILITY	YES	NO	Assistance Needed/Comments:
Cares for self at toilet			
Bathes/showers independently			
Brushes teeth & combs hair			
Dresses independently			
Wakes up cooperatively			
Goes to bed cooperatively			
Needs afternoon nap			
Walks independently:			
on level ground			
on hills/trails/rough terrain			
for longer distances			
Enjoys running/active games			
MEALTIME NEEDS	YES	NO	Assistance Needed/Comments:
Completely independent at meals			
Has dietary restrictions (Please explain)			
SOCIAL SKILLS	YES	NO	Assistance Needed/Comments:
Desires to come to Camp			
Makes friends			
Follows directions easily			
Participates in group activities			
Will stay with counselor & group			
Communicates clearly using speech			
Is cooperative and compliant			

Please share any concerns or observations about this camper that may help us assess program needs.

Thank you for your honesty and care in filling out this form.
 A more comprehensive health/behavior form will be sent to you with registration confirmation.