February 16, 2024

Dear Peer Camper,

Peer Camper is a support position at Camp *WANNAGOAGAIN!* Peer Campers must be at least 14 years old at the time of camp and submit the attached application. As a Peer Camper, you will support your peers in all camp activities and serve as a role model for our campers, *Camper to Camper*.

Camp will be returning to the same location as last year. Camp Aquapaug is located 1698 Ministerial Road, South Kingstown, RI 02879. The camp is beautiful and a good fit for our camp too.

You will participate in all activities, including swimming, arts and crafts, unified sports and our special activities. This is a rewarding place to learn more about the Autism Spectrum Disorder, make lasting friendships and have fun!

Kindly submit the completed the application to Cathy Young, no later than Friday, July 12, 2024.

Peer Camper applications can be mailed to The Autism Project, faxed or emailed directly to Cathy Young at catherine.young@lifespan.org. Our camp directors may reach out to schedule a phone interview to help determine the best placement. As always, please contact us with any questions or concerns.

We look forward to another successful year of Camp *WANNAGOAGAIN!*

Joanne G. Quinn
Executive Director
P 401-785-2666
F 401-785-2272

Important Dates

JULY 12, 2024 DEADLINE FOR PEER CAMPER REGISTRATION

JULY 19, 2024 PLACEMENT CONFIRMED BY MAIL

**You can apply any time and if you apply early, we will confirm placement early for you to plan your summer around your time at camp!

****

CAMP SET-UP AND OPEN HOUSE:
Saturday, July 20th, 3pm – 5pm
LOCATION: Camp Aquapaug
1698 Ministerial Road, South Kingston, RI 02879

CAMP SESSION ONE:
July 22nd-26th, 2024
Monday – Thursday from 9am – 3pm
Friday from 9am – 1pm

CAMP SESSION TWO:
July 29-August 2, 2024
Monday – Thursday from 9am – 3pm
Friday from 9am – 1pm

CAMP SESSION THREE:
August 5-9, 2024
Monday – Thursday from 9am – 3pm
Friday from 9am – 1pm

CAMPER TO CAMPER ORIENTATION:
Tuesday, July 23rd 10-11:30 am located at The Autism Project office (address below)

Please mail registration packet to:
The Autism Project
Attention: Cathy Young
1516 Atwood Ave.
Johnston, RI 02919

Or e-mail registration packet to Cathy Young at catherine.young@lifespan.org

We look forward to another fun summer at Camp *WANNAGOAGAIN!*

Camp Wannagoagain!
Camper to Camper Registration

Peer Camper's Name:		Pronouns:	
DOB:	Grade:	Age:	Gender:
Address:	City:	State:	Zip:
Cell Phone:	Email Address:		
T-Shirt Size	**Adult:** ☐S ☐M ☐L ☐XL ☐XXL ☐ Other (Please Specify):		
Does the Peer Camper have an ASD Diagnosis?	☐ Yes ☐ No ☐ Other (Please Specify):		
Prior Camp Volunteer:	☐Yes ☐No		
I am interested in attending:	**Week 1** ☐ **Week 2** ☐ **Week 3** ☐	*Please check all that apply	
Any accommodations or conflicts?			

PARENT/LEGAL GUARDIAN INFORMATION

Name(s) of Parent(s)/Caregiver(s):			
Address:	City:	State:	Zip:
E-mail:	Home#:	Cell#:	

Emergency Contact #1 Name:		
Relationship:	Home#:	Cell#:
Emergency Contact #2 Name:		
Relationship:	Home#:	Cell#:

Emergency Medical Information

Physician's Name: Phone#:
Current Medications:
Allergies:
Food/Dietary Restrictions:
Seizures (yes/no):
Other:
Treatment for any of the above that The Autism Project may need to perform. ☐ Epi Pen *Doctor's order required*
In case of emergency, I understand that every effort will be made to contact me, or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 911 protocol and have my child taken to the nearest hospital.
Signature of Parent/Guardian: **Date:**

Peer Camper Name: _____

Please attach a photo of yourself here →

We want to learn more about you! Please write a short summary about yourself and what interests you to work with people on the Autism Spectrum. Also, include any related experience you may have had with other individuals with special needs.

Transportation Information

PERMISSION TO PICKUP PEER CAMPER (IF UNDER 18)

PLEASE COMPLETE THE FOLLOWING INFORMATION IN THE EVENT THAT SOMEONE OTHER THAN YOURSELF MAY PICK UP YOUR PEER CAMPER FROM CAMP. PLEASE NOTE THAT WE MAY ASK THAT PERSON TO PRESENT IDENTIFICATION TO VERIFY THEIR IDENTITY.

NAME	RELATIONSHIP	PHONE #

If there is available space on the bus I would like transportation to and from camp from Johnston High School:

☐ **Yes** ☐ **No**

I, on behalf of myself and the participant, hereby release, indemnify, quit and hold harmless, and forever discharge The Autism Project and its affiliates and its and their respective governors, directors, officers, employees, and agents from and against any and all liabilities, obligations, damages, penalties, claims, actions, causes of action, demands, judgments, executions, costs (including reasonable attorneys fees), charges, loss of services, expenses, compensation, and any and all other claims whatsoever, both at law and in equity, which I may incur or may assert in connection with bus/van transportation as described herein.

_____ (initial here)

I hereby authorize, acknowledge, and accept the risks involved in transporting my child to and from Camp WANNAGOAGAIN (1698 Ministerial Road, South Kingstown, RI) in a van or bus.

_____ (initial here)

I understand that drop off will be at 8:00am Monday-Friday in Johnston High School Rear Parking Lot. I further understand that pick up will be at the same location, at 3:30pm Monday-Thursday, and at 1:30pm on Friday.

_____(initial here)

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

☒ Interview ☒ Video ☒ Photography ☒ Broadcast

Date: 2024

Authorization and Release
For Photography/Audio and Videotaping/ Broadcasting/Interviewing (When Protected Health Information is Involved)

Initial Use: **The Autism Project's Camp Wannagoagain!**

Patient description _____

use if multiple patients photographed for initial use. Ex yellow shirt, tall, etc.

Patient Name (please print): _____

Patient Address (city/state zip): _____

Patient Date of Birth: _____ **Patient Phone #:** _____ **Patient Email:** _____

As applicable and as further described below, I authorize Lifespan and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction"). Describe nature of Permitted Interaction (i.e., context of interview, event at which photos are to be taken, etc.) and nature of protected health information to be gathered about patient:

I authorize the Lifespan Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media, including, but not limited to, The Autism Project's website, X (formerly Twitter), Instagram, and Facebook accounts, for advertising, marketing, fundraising, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).

I authorize Lifespan and its affiliates to copyright any photographs, videos, and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.

I understand that, to the extent the content of the Permitted Interaction contains my protected health information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I understand that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan from all liability arising from this disclosure of my health information.

I understand this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:

Lifespan Marketing and Communications
117 Ellenfield Street, Suite 100
Providence, Rhode Island 02905

I understand that any previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Lifespan.

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

Volunteer Agreement and Release:

I, _____ (your name) agree to volunteer at Camp WANNAGOAGAIN 2023 hosted by The Autism Project (a Lifespan Partner). I understand that participation in camp may involve activities with a certain degree of risk and which may be physically, mentally, and emotionally demanding. I also understand that participation in these activities is completely voluntary and requires me to abide by applicable rules and standards as determined by The Autism Project Staff. Failure to comply with these rules and standards may jeopardize the safety of myself and others, and may result in my dismissal from camp. I agree, to the best of my ability, to follow all instructions, attend all trainings, and ask for help if needed. I acknowledge that I have carefully considered these risks and obligations and voluntarily accept them. I also understand that in volunteering at camp, I am responsible for myself and any property I bring to camp. Furthermore, I understand that confidentiality is a critical component of camp, and client specifics may never be used or discussed outside of camp.

_____ _____

Signature of Peer Camper Date

_____ _____

Signature of Parent/Guardian (if under 18) Date