Camp Wediko

Dear Parent or Guardian:

Thank you for your interest in Camp Wediko!

In this packet you will find a full application to refer your child to Camp Wediko. We ask that parents/guardians complete their portion of the application. The Teacher and Mental Health Provider forms are included in this packet. Please note, our application is available online at www.campwediko.org.

When completing the Parent/Guardian Form, please answer all questions thoroughly and openly. The more you share about your family, the more our team will know how to help your child. Confidentiality of our clients is very important at Wediko and require that you complete the Authorization to Release Information Form for each person with whom you would like us to speak.

The two-way authorization allows Wediko and another professional to share information verbally and in writing for the purpose of this referral and for treatment over the summer. Please feel free to make extra copies of this form as needed for the child's school, therapist, medical providers, educational consultant or anyone else.

Along with the referral forms, it is very helpful to include information about your child, such as: reports, evaluations, IEP, psychological testing and/ or hospital discharge summaries.

All three forms and the Authorization to Release Information Forms are needed to complete the application to refer your child to Camp Wediko. All completed forms are needed before we schedule an interview with you. Please forward all forms and any other relevant materials by mail, email or fax to:

Wediko Children's Services
Attn: Camp Wediko
72-74 East Dedham Street
Boston, MA 02118
Fax: 617-292-9275
wedikosummer@wediko.org

If you have any questions about the admissions process, please contact our Camp Wediko Team at 617-292-9200 or wedikosummer@wediko.org.

Thank you in advance for your interest in Camp Wediko!

Sincerely,

Camp Wediko Team

Camp Wediko

Camper Application
Parent/Guardian Form

Child's Name: _____ DOB: _____

Please explain the reason you are applying to Camp Wediko? Be as specific and detailed as possible.

_____

_____

_____

_____

About You

Your Name: _____

Child's relationship to you (Check all that apply):

- ☐ Biological child
- ☐ Foster child
- ☐ Step-child
- ☐ Other: _____
- ☐ Adopted child
- ☐ Grandchild
- ☐ A client of mine

Family Information

Name of Parent/Guardian 1: _____

Address: _____

Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Remarried

Name of Parent/Guardian 2: _____

Address: _____

Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Remarried

Emergency Contact: _____

Address: _____

Phone: _____ Email: _____

Family's religion(s) or spiritual preferences: _____

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Family Composition

Child's primary residence(s):

Name	Age	Relationship to child

Family members living elsewhere:

Name	Age	Relationship	Location

Child's Information

Child's preferred name: _____

Child's gender (check one): □ Female □ Transgender □ Other: _____
□ Male □ Gender-nonconforming

If applicable, preferred gender pronouns (check one): □ She, her, hers; □ He, him, his;
□ They, their, theirs; □ Unsure □ Other: _____

Height: _____ Weight: _____

Shirt size: _____ Pants size: _____ Shoe size: _____

Child's three favorite foods: _____

Child's three least favorite foods: _____

Child's extra-curricular activities and interests: _____

_____

Birthplace (city, state, country): _____

What age did child start school: _____

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Academic Information

Child's current grade: _____ Expected grade next academic year: _____

School name: _____

Address: _____

Phone: _____ Email: _____

Does the child have an Individualized Education Program (IEP)?	□ Yes	□ No	□ Unsure
Does the child have a 504 accommodation Plan?	□ Yes	□ No	□ Unsure
Will there be changes to the child's school placement next year?	□ Yes	□ No	□ Unsure
Does the child have a history of suspensions:	□ Yes	□ No	□ Unsure
Does the child have a history of expulsions:	□ Yes	□ No	□ Unsure
Are the child's educational/learning needs currently being met?	□ Yes	□ No	□ Unsure
Did the child ever have to repeat one or more grades?	□ Yes	□ No	□ Unsure

Comments: _____

Child's Health Information

□ Does the child have any food allergies?	Details: _____
□ Does the child have environmental allergies?	Details: _____
□ Does the child need/use an EPI pen?	Details: _____
□ Does the child have asthma?	Details: _____
□ Does the child have a history of head injury?	Details: _____
□ Does the child have a history of seizures?	Details: _____
□ Does the child have Diabetes Type 1 or II?	Details: _____
□ Does the child have a history of cardiac issues?	Details: _____
□ Does the child have a history of bleeding disorders?	Details: _____
□ Does the child have any activity restrictions?	Details: _____

Please list any dietary restrictions for the child: _____

_____

Please list any current medical diagnosis(es) or health concerns for the child (do not include psychiatric diagnoses): _____

_____

Please list any current medication the child takes for medical issues (do not include psychiatric medications):

_____

Developmental History

Check all that apply. Explain in the section below.

- ☐ Complications during pregnancy, labor or childbirth? Details: _____
- ☐ Neonatal illnesses or other stressors after birth? Details: _____
- ☐ Neonatal problems with feeding or weight gain? Details: _____
- ☐ Major medical problems since birth? Details: _____
- ☐ Developmental delays? Details: _____
- ☐ Receive early intervention? Details: _____
- ☐ Problems with vision? Details: _____
- ☐ Problems with hearing? Details: _____
- ☐ Problems with bed wetting? Details: _____
- ☐ Problems with day time wetting or soiling? Details: _____
- ☐ Sleep problems? Details: _____
- ☐ Eating problems? Details: _____

Mental Health History

When did the child first display signs that they may have special needs:

Age: _____ Problem: _____

Age: _____ Problem: _____

Age: _____ Problem: _____

Current mental health diagnose(s): _____

_____

Any previous mental health diagnose(s): _____

_____

IQ testing date(s) and results: _____ Date: _____

Please list ages. First outpatient treatment: _____ First psychiatric medication: _____

Current psychiatric medication(s):

Medication	Dose	Reason

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Mental Health History Cont'd.

Please list previous psychiatric medication(s) used or tried: _____

_____

List psychiatric hospitalizations. Include dates ranging from admission to discharge.

If more than two hospitalizations, check here [ ].

Dates: _____ Hospital name: _____

Reason: _____

Dates: _____ Hospital name: _____

Reason: _____

Psychiatric or school placements outside of the home (i.e.: Partial hospital, CBAT, residence).

Include dates ranging from admission to discharge. If more than two placements, check here [ ].

Dates: _____ Name of placement: _____

Reason: _____

Dates: _____ Name of placement: _____

Reason: _____

Family history of mental illness or substance abuse:

Relationship to Child	Describe Issue

History of trauma (child): Check and give details for each trauma the child experienced, including age when trauma occurred.

- □ Physical abuse Ages: _____ Details: _____
- □ Sexual trauma Ages: _____ Details: _____
- □ Emotional abuse Ages: _____ Details: _____
- □ Neglect Ages: _____ Details: _____
- □ Loss of parent Ages: _____ Details: _____
- □ Medical trauma Ages: _____ Details: _____
- □ Traumatic separation Ages: _____ Details: _____
- □ Exposure to domestic violence Ages: _____ Details: _____
- □ Exposure to parental substance abuse Ages: _____ Details: _____
- □ Other identified traumas Ages: _____ Details: _____

Mental Health History Cont'd.

History of high risk behaviors/symptoms (child): Check all that apply. Provide details below.

- ☐ Fire setting — Ages: _____ Details: _____
- ☐ Property destruction — Ages: _____ Details: _____
- ☐ Suicide attempts — Ages: _____ Details: _____
- ☐ Self-harm behaviors — Ages: _____ Details: _____
- ☐ Risky online behaviors — Ages: _____ Details: _____
- ☐ Vaping/smoking — Ages: _____ Details: _____
- ☐ Alcohol/drug use/abuse — Ages: _____ Details: _____
- ☐ Eating Disorder — Ages: _____ Details: _____
- ☐ School avoidance/truancy — Ages: _____ Details: _____
- ☐ Harm of animals/pets — Ages: _____ Details: _____
- ☐ Legal involvement — Ages: _____ Details: _____
- ☐ Stealing — Ages: _____ Details: _____
- ☐ Weapons use — Ages: _____ Details: _____
- ☐ Running away — Ages: _____ Details: _____
- ☐ Social withdrawal — Age: _____ Details: _____
- ☐ Risky sexual behavior — Ages: _____ Details: _____
- ☐ Compulsive sexual behavior — Ages: _____ Details: _____
- ☐ Bullying behavior — Ages: _____ Details: _____
- ☐ Violent behavior — Ages: _____ Details: _____
- ☐ Symptoms of psychosis — Ages: _____ Details: _____
- ☐ Sexual abuse of other — Ages: _____ Details: _____

The Modified Overt Aggression Scale (MOAS)*

*Modified from Kay SR, Wolkenfelf F, Murrill LM (1988), Profiles of aggression among psychiatric patients: I. nature and prevalence. Journal of Nervous and Mental Disease 176:539-546. Evaluation period extended from 1 week to 1 month.

Please rate the child's aggressive behavior over the past month. Check all and as many items as are appropriate.

Verbal aggression

_____ 0 No verbal Aggression
_____ 1 Shouts angrily, curses mildly, or makes personal insults
_____ 2 Curses viciously, is severely insulting, has temper outbursts
_____ 3 Impulsively threatens violence toward others or self
_____ 4 Threatens violence toward others or self repeatedly or deliberately

The Modified Overt Aggression Scale (MOAS)* Cont'd.

Aggression against Property
_____ 0 No aggression against property
_____ 1 Slams door, rips clothing, urinates on floor
_____ 2 Throws objects down, kicks furniture, defaces walls
_____ 3 Breaks objects, smashes windows
_____ 4 Sets fires, throws objects dangerously

Autoaggression
_____ 0 No autoaggression
_____ 1 Picks or scratches skin, pulls hair out, hits self (without injury)
_____ 2 Bangs head, hits fists into walls, throws self onto floor
_____ 3 Inflicts minor cuts, bruises, burns, or welts on self
_____ 4 Inflicts major injury on self or makes a suicide attempt

Physical Aggression
_____ 0 No physical aggression
_____ 1 Makes menacing gestures, swings at people, grabs at clothing
_____ 2 Strikes, pushes, scratches, pulls hair of others (without injury)
_____ 3 Attacks others, causing mild injury (bruises, sprain, welts, etc.)
_____ 4 Attacks others, causing serious injury

Additional Information

Were you referred or recommended to Camp Wediko? ☐ Yes ☐ No

If yes: who referred you or recommended Wediko for the upcoming summer?

Name: _____ Relationship: _____ Phone: _____

Please list any previous years the child attended Camp Wediko: _____

Please list your child's three biggest challenges or struggles at this time.

1. _____
2. _____
3. _____

Please list your child's three best qualities.

1. _____
2 _____
3. _____

Please describe any major family stressors that you are experiencing at this time.

_____

_____

Additional Information Cont'd.

What would you hope for your child to gain from the Camp Wediko experience?

What would you hope to gain as a parent from the Camp Wediko experience?

If your child is accepted to the program, how would you like to participate in family therapy this summer?

□ At the Wediko Boston office □ On-site in New Hampshire □ By phone

Please state any concerns you have about your child's participation at Camp Wediko, if accepted.

Contact Information

Pediatrician:
Address:
Phone: Email:
Therapist:
Address:
Phone: Email:
Psychiatric Provider:
Address:
Phone: Email:
Dentist:
Address:
Phone: Email:
Other:
Address:
Phone: Email:

Contact Information Cont'd.

State or private agencies involved with child:

Agency: _____ Contact: _____

Address: _____

Phone: _____ Email: _____

Agency: _____ Contact: _____

Address: _____

Phone: _____ Email: _____

Program Logistics

Please indicate person or agency that will pay the tuition if your child is accepted.

Name: _____

Address: _____

Phone: _____ Email: _____

Agency or School District Name (if applicable): _____

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Camp Wediko

Dear Mental Health Provider,

Thank you for assisting in the referral process to Camp Wediko!

Camp Wediko offers 45-day intensive mental health treatment camp for children and adolescents ages 8-19. We specialize in working with youth who have difficulty engaging with traditional treatment models; or in need of a highly-structured therapeutic interventions in order to achieve emotional and behavioral stability. Some of the diagnoses we treat include autism spectrum disorder, learning disabilities, ADHD, bipolar disorder, depression, reactive attachment disorder, trauma related disorders and social anxiety

This packet includes the mental health provider portion of the application. Please complete the form. Confidentiality of our clients is very important at Wediko and require that an Authorization to Release Information Form is completed so that we may exchange information with you verbally or in writing for the purpose of this referral and for treatment over the summer. We ask that you assist the parent as needed in completing this form.

Along with the referral forms, it is very helpful to include information about the child, such as: reports, evaluations, IEP, psychological testing and/or hospital discharge summaries. Please forward all forms and any other relevant materials by mail, email or fax to:

Wediko Children's Services
Attn: Camp Wediko
72-74 East Dedham Street
Boston, MA 02118
Fax: 617-292-9275
wedikosummer@wediko.org

If you have any questions about the admissions process, please contact our Camp Wediko Team at 617-292-9200 or wedikosummer@wediko.org.

We look forward to working with you!

Sincerely,

Camp Wediko Team

Camp Wediko

Camper Application
Mental Health Provider Form

Child's Name: _____ DOB: _____

About You

Your Name: _____

Your Title: _____

Name of Agency: _____

Address: _____

Phone: _____ Email: _____

Date you first began working with the child: _____

What was the reason for the referral? _____

_____

What service(s) do you provide to the child? _____

_____

What is the frequency of your service(s)? _____

Child's Information

Child's current mental health diagnose(s): _____

_____

Child's current psychiatric medications (if applicable): _____

_____

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Child's Information Cont'd.

Please list any other mental health professionals you collaborate with for the child's care/treatment.

Name: _____

Role: _____ Phone: _____

Name: _____

Role: _____ Phone: _____

Name: _____

Role: _____ Phone: _____

Are there any concerns regarding the child's participation/attendance with your service(s)?

□ Yes □ No

If yes, details: _____

Please list any specific treatment model(s) you utilize in the service(s) you provide.

_____

_____

To your knowledge, does the child identify as LGBTQ+?

□ Yes □ No □ Unsure

To your knowledge, are the child's educational/learning needs appropriately met in the current school setting?

□ Yes □ No □ Unsure

Comments: _____

Please list psychiatric or school placements outside of the home (i.e., Hospitalization, partial hospital, CBAT, residence, if applicable). If more than three placements, check here [ ].

Name of placement: _____ Dates: _____

Reason: _____

Name of placement: _____ Dates: _____

Reason: _____

Name of placement: _____ Dates: _____

Reason: _____

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Mental Health History

History of trauma (child): Check and give details for each trauma the child experienced, including age when trauma occurred.

- ☐ Physical abuse Ages: _____ Details: _____
- ☐ Sexual trauma Ages: _____ Details: _____
- ☐ Emotional abuse Ages: _____ Details: _____
- ☐ Neglect Ages: _____ Details: _____
- ☐ Loss of parent Ages: _____ Details: _____
- ☐ Medical trauma Ages: _____ Details: _____
- ☐ Traumatic separation Ages: _____ Details: _____
- ☐ Exposure to domestic violence Ages: _____ Details: _____
- ☐ Exposure to parental substance abuse Ages: _____ Details: _____
- ☐ Other identified traumas Ages: _____ Details: _____

History of high risk behaviors/symptoms (child): Check all that apply. Provide details below.

- ☐ School avoidance/truancy Ages: _____ Details: _____
- ☐ Harm of animals/pets Ages: _____ Details: _____
- ☐ Legal involvement Ages: _____ Details: _____
- ☐ Stealing Ages: _____ Details: _____
- ☐ Has negative peer group Ages: _____ Details: _____
- ☐ Defies authority Ages: _____ Details: _____
- ☐ Weapons use Ages: _____ Details: _____
- ☐ Running away Ages: _____ Details: _____
- ☐ Social withdrawal Age: _____ Details: _____
- ☐ Risky sexual behavior Ages: _____ Details: _____
- ☐ Compulsive sexual behavior Ages: _____ Details: _____
- ☐ Bullying behavior Ages: _____ Details: _____
- ☐ Fire setting Ages: _____ Details: _____
- ☐ Property destruction Ages: _____ Details: _____
- ☐ Suicide attempts Ages: _____ Details: _____
- ☐ Self-harm behaviors Ages: _____ Details: _____
- ☐ Risky online behaviors Ages: _____ Details: _____
- ☐ Vaping/smoking Ages: _____ Details: _____
- ☐ Alcohol use/abuse Ages: _____ Details: _____
- ☐ Drug use/abuse Ages: _____ Details: _____
- ☐ Eating Disorder Ages: _____ Details: _____

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Mental Health History Cont'd.

History of high risk behaviors/symptoms (child): Check all that apply. Provide details below.

- ☐ Violent behavior — Ages: _____ Details: _____
- ☐ Symptoms of psychosis — Ages: _____ Details: _____
- ☐ Sexual abuse of other — Ages: _____ Details: _____

The Modified Overt Aggression Scale (MOAS)*

*Modified from Kay SR, Wolkenfelf F, Murrill LM (1988), Profiles of aggression among psychiatric patients: I. nature and prevalence. Journal of Nervous and Mental Disease 176:539-546. Evaluation period extended from 1 week to 1 month.

Please rate the child's aggressive behavior over the past month. Check all and as many items as are appropriate.

Verbal aggression
_____ 0 No verbal Aggression
_____ 1 Shouts angrily, curses mildly, or makes personal insults
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_____ 4 Threatens violence toward others or self repeatedly or deliberately

Aggression against Property
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_____ 2 Throws objects down, kicks furniture, defaces walls
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Physical Aggression
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_____ 1 Makes menacing gestures, swings at people, grabs at clothing
_____ 2 Strikes, pushes, scratches, pulls hair of others (without injury)
_____ 3 Attacks others, causing mild injury (bruises, sprain, welts, etc.)
_____ 4 Attacks others, causing serious injury

Additional Information

Please list the child's three biggest struggles or challenges at this time.

1. _____
2. _____
3. _____

Please list three strengths the child shows in treatment.

1. _____
2 _____
3. _____

Please describe the involvement of the child's family in your service(s).

_____

_____

_____

Please check and provide details for any current family stressors:

- ☐ Financial stressors
- ☐ Unstable or inadequate housing
- ☐ Parental unemployment
- ☐ Family member with chronic illness
- ☐ Incarcerated family member
- ☐ Family coping with grief and loss
- ☐ Conflict between parents/caregivers
- ☐ Domestic violence
- ☐ Parent or family member with mental illness
- ☐ Parent or family member with substance abuse
- ☐ Other: _____

Comments:

_____

_____

Please describe any unmet needs that the child or family has at this time.

_____

_____

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Camp Wediko

Dear Teacher,

Thank you for assisting in the referral process to Camp Wediko!

Camp Wediko offers 45-day intensive mental health treatment camp for children and adolescents ages 8-19. We specialize in working with youth who have difficulty engaging with traditional treatment models; or in need of a highly-structured therapeutic interventions in order to achieve emotional and behavioral stability. Some of the diagnoses we treat include autism spectrum disorder, learning disabilities, ADHD, bipolar disorder, depression, reactive attachment disorder, trauma related disorders and social anxiety

This packet includes the teacher portion of the application. Please complete the form. It can be completed by any appropriate teacher or school staff. Confidentiality of our clients is very important at Wediko and require that an Authorization to Release Information Form is completed so that we may exchange information with you verbally or in writing for the purpose of this referral and for treatment over the summer. We ask that you assist the parent as needed in completing this form.

Along with the referral forms, it is very helpful to include information about the child, such as: reports, evaluations, IEP, psychological testing and/or hospital discharge summaries. Please forward all forms and any other relevant materials by mail, email or fax to:

Wediko Children's Services
Attn: Camp Wediko
72-74 East Dedham Street
Boston, MA 02118
Fax: 617-292-9275
wedikosummer@wediko.org

If you have any questions about the admissions process, please contact our Camp Wediko Team at 617-292-9200 or wedikosummer@wediko.org.

We look forward to working with you!

Sincerely,

Camp Wediko Team

Camp Wediko

Camper Application
Teacher Form

Child's Name: _____ DOB: _____

About You

Your name: _____

Your position: _____

School name: _____

Address: _____

Phone: _____ Email: _____

Child's Information

Current grade: _____ Expected grade next academic year: _____

Type of school: ☐ Private ☐ Public ☐ Charter ☐ Other: _____

Academic Information

Child's current grade level functioning:

Math: _____ Reading: _____ Writing: _____

At Wediko, we utilize child's interests to engage them in the academic curriculum. Please use this space to indicate the child's academic interests. Examples may include: World War II, animals, science fiction, trains, comic books, volcanoes, etc.

1. _____
2. _____
3. _____

Child's favorite subjects:

1. _____
2. _____
3. _____

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Academic Information Cont'd.

Child's least favorite subjects:

1. _____
2. _____
3. _____

Please list any learning disabilities or difficulties that the child has identified:

_____

_____

Number of days absent this academic year: _____

Number of days late to school this academic year: _____

Special Education Information

Does the child have an Individualized Education Program (IEP)? ☐ Yes ☐ No

If yes, percent of time in special education setting: _____

Teacher: child ratio: _____

Qualifying Disability(s) for IEP services: _____

Please describe program outlined in IEP, class placement, services, therapies, accommodations, supports, etc. (Please attach IEP if possible.)

_____

_____

_____

_____

_____

_____

_____

Age/grade of child's initial IEP: _____

Previous special education placements (if any):

School: _____ Class/Program: _____ Dates: _____

School: _____ Class/Program: _____ Dates: _____

School: _____ Class/Program: _____ Dates: _____

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Special Education Information Cont'd.

Summary of IQ and Achievement Testing

Test Administered: _____ Date: _____

Results: _____

Test Administered: _____ Date: _____

Results: _____

Test Administered: _____ Date: _____

Results: _____

Child's Strengths and Needs

Child's top three strengths as a student:

1. _____
2. _____
3. _____

For your point of view, what are the child's biggest struggles or challenges at this time?

_____

_____

What type of learner is the child? (i.e.: visual, auditory, kinesthetic, etc.). Please provide examples:

_____

_____

Please list strategies you have found helpful in working with this child.

_____

_____

Please list strategies you have tried that have **not** been successful in working with this child.

_____

_____

Please list any supports that you feel the child needs or may benefit from that are not yet in place.

_____

_____

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Risk Factors

Please check all that apply:

- ☐ Failing class(es)
- ☐ Frequent lateness
- ☐ Cutting Class
- ☐ Truancy
- ☐ Social isolation
- ☐ Bully to others
- ☐ Bullied by others
- ☐ LGBTQ+ identity
- ☐ Poor hygiene
- ☐ Sexualized behaviors
- ☐ Sexually aggressive
- ☐ Verbally aggressive
- ☐ Physically aggressive
- ☐ Mood swings
- ☐ Running away
- ☐ Stealing
- ☐ Suspensions
- ☐ Weapon in school
- ☐ Negative peer group
- ☐ Destruction of property
- ☐ Suicidal/self-harm behavior
- ☐ Alcohol/substance abuse

Details: _____

The Modified Overt Aggression Scale (MOAS)*

*Modified from Kay SR, Wolkenfelf F, Murrill LM (1988), Profiles of aggression among psychiatric patients: I. nature and prevalence. Journal of Nervous and Mental Disease 176:539-546. Evaluation period extended from 1 week to 1 month.

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Autoaggression

_____ 0 No autoaggression
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_____ 2 Bangs head, hits fists into walls, throws self onto floor
_____ 3 Inflicts minor cuts, bruises, burns, or welts on self
_____ 4 Inflicts major injury on self or makes a suicide attempt

Physical Aggression

_____ 0 No physical aggression
_____ 1 Makes menacing gestures, swings at people, grabs at clothing
_____ 2 Strikes, pushes, scratches, pulls hair of others (without injury)
_____ 3 Attacks others, causing mild injury (bruises, sprain, welts, etc.)
_____ 4 Attacks others, causing serious injury

Camp Wediko

Authorization to Release Information

Child's Name: _____ Date of Birth: _____

Child's Address: _____

Information to be Released/Obtained

This authorization allows Wediko Children's Services and another entity to exchange information that will assist in providing clinical services to the client identified above. Information to be released/obtained about the client's treatment may include sensitive medical and personal information. The types of information to be exchanged includes but is not limited to: mental health treatment records, academic information, information about medical conditions and care, psychiatric evaluations, treatment summaries and other information shared verbally that is pertinent to the clinical services provided by Wediko Children's Services. If authorizing the release of HIV-related, sexual assault related, or alcohol and drug treatment related information, the recipient is prohibited from the re-disclosure such information without authorization unless permitted to do so under federal or state law. To better understand about the information being released or obtained, speak to your therapist and/or health administrator.

□ Medical records from the following dates: _____ to _____

□ Evaluations □ Other: _____

□ Included (Please indicate with initials):

_____ HIV related information _____ Sexual assault treatment _____ Alcohol/Drug treatment

Provider/Agency: _____ Phone: _____

Provider/Agency Address: _____

Revocation and Time Limit

I understand that signing this authorization is voluntary. I can change my decision and have this authorization revoked at any time with a request to Wediko Children's Services. I understand that I may revoke this authorization, however the materials that have already been released to Wediko Children's Services or other agencies under the authorization will be valid for use. This authorization is valid for one year after the date signed, unless a cancellation request is submitted. Information disclosed under this authorization may be re-disclosed by the recipient, and that such re-disclosure is no longer protected by federal or state law. I authorize Wediko Children's Services and the above-named agency/provider to release/obtain information pertinent to the client's care and treatment. I agree to release Wediko Children's Services, its officers, directors, employees and associated professionals, clinicians, and therapists from any liability that arise from the release of this information to any individual or agency/provider listed above.

_____ _____

Name of Parent/Guardian/Agency Representative | Relationship to client

_____ _____

Signature of Parent/Guardian/Agency Representative | Date

Updated: 01/14/19

Wediko CHILDREN'S SERVICES
72-74 East Dedham Street
Boston, MA 02118
Camp Wediko is a division of Wediko Children's Services.
campwediko.org
@wediko

Camp Wediko Fund Agreement

I, _____ (parent/guardian/school district/agency), agree to fund child, _____, to attend Camp Wediko.

Please provide the billing information below.

Billing Information:

Contact Name: _____

School District/Agency (if applicable): _____

Street Address: _____

City, State, Zip: _____

Email: _____

Phone Number: _____

Insurance Policy:
I understand that Wediko Children's Services may provide the child's progress reports at the request of the authorized guardian. Wediko Children's Services will not provide documentation for medical insurance purposes including but not limited to: insurance codes, therapy hours or rates for insurances.

_____ _____

Signature Name of Parent/Guardian/Agency Representative Date

_____

Name of Parent/Guardian/Agency Representative

Please fill out and sign this form. Email completed form to wedikosummer@wediko.org or fax to 617-292-9275, Attn: Camp Wediko Admissions. Upon receipt and verification, Wediko will send you an invoice. If you have any questions, contact Lawrence Mayo or Tamara Laine: (617) 292-9200.

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