# Summer Youth

# WORK EXPERIENCE

Building Soft Skills for Employment for

Students Between the Ages 18-22



*Space is limited. First-come, first-served.

**Monday - Friday 8:45 a.m. to 2:30 p.m.**

**Camp Dates: June 26th through July 28th**

*Registration at a later date.

## WORK EXPERIENCE BOOT CAMP includes:

- Volunteer Work
- Self-Advocacy
- Social Skills / Communication in the Workplace
- Proper Workplace & Interview Attire
- Completing Applications
- Occupational Interest Surveys
- Guest Speakers & Touring Businesses

## Who Can Register?

- Any Student (ages 18-22)
- Must Reside in Montgomery or Greene County
- Must be Board Eligible or Seeking Eligibility

## Where is Boot Camp Held?

Miami Valley Regional Center
4801 Springfield St., Dayton, OH 45431

For more information, contact:

Andrea Harker, Montgomery County Board of DDS
(937) 247-2450 or aharker@mcbdds.org

Kathy Kleiser, Greene County Board of DDS
(937) 562-6529 or kkleiser@greenedd.org

Provided by:

MONTGOMERY COUNTY Board of Developmental Disabilities Services

EMPLOYMENT FIRST

GREENE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
GCBDD
A Lifetime of Dignity and Opportunity

# Summer Youth WORK EXPERIENCE


# APPLICATION

## Important Information

- Each application will be reviewed to determine if the selection made is appropriate for the student.
- The Summer Youth Boot Camp cannot provide personal care, an aide, or nursing services.
- Students are required to bring a packed lunch.

*In order to complete your application, the following forms must be completed and returned to our offices, **no later than May 25, 2017**.

**__ Application**

**__ Emergency Medical Form**

**__ Release of Information**

**__ Sign and date Policy and Procedures Form (located in back of handbook)**

*Remember your camper will not be registered until all forms are completed. Camp slots are filled on a first- come, first-served basis, determined by when all forms are received.

**Mail all applications to:**

**Montgomery County Residents**

Andrea Harker
MCBDDS
700 Liberty Lane
West Carrolton, OH 45449
Phone: (937) 247-2450
Email: aharker@mcbdds.org
Fax: (937) 247-2424 Attn: Andrea Harker

**Greene County Residents**

Kathy Kleiser
GCBDDS
245 Valley Road
Xenia, OH 45385
Phone: (937) 562-6529
Email: kkleiser@greenedd.org
Fax: (937) 562-6539 Attn: Kathy Kleiser

**Provided by:**

MONTGOMERY COUNTY
**Board of Developmental Disabilities Services**

GREENE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
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# Application

## Part 1 - Guardian Information

First name: _____ Last name: _____

Relationship to Camper: _____

Cell phone: _____ Other Phone: _____

Address: _____ Apt.: _____

City: _____State: _____ Zip: _____

Email address: _____

**Second Guardian (Optional)**

First name: _____ Last name: _____

Relationship to Camper: _____

Cell phone: _____ Other Phone: _____

Address: _____ Apt.: _____

City: _____State: _____ Zip: _____

Email address: _____

## Part 2: Camper Information

First name: _____ Last name: _____ Gender (circle): M F

Current Age: _____ Date of Birth: _____ (MM/DD/YYYY)

School: _____ Grade: _____

Teacher (Responsible for IEP): _____

Is the student connected with Montgomery or Greene County DD services? Yes No

Would you like more information about eligibility? Yes No

Is the student connected with Opportunities for Ohioans with Disabilities (OOD)? Yes No

Name of OOD counselor? _____

Does the student have any paid employment or volunteer experience? Yes No If yes, please list below:

Paid employment: _____

Volunteer: _____

## Part 3: Work Experience Dates

**Dates of Work Experience Boot Camp: June 26 through July 28**

***Camp will not take place on July 3rd and July 4th.**

****Camp registrations will be prioritized for campers that can attend all 4 weeks of camp (excluding July 3-7).**

# Greene and Montgomery County Boards of DD Boot Camp Emergency Medical Form

| | | | | | |
|---|---|---|---|---|---|
| Name: | | | | | |
| Address: | | | | | |
| City: | State: | Zip: | Phone: | DOB: | |
| School District/School Attending: | | | | Teacher: | |

Guardian: ☐ No ☐ Yes Guardian Name: _____ Phone: _____

☐ **I give consent for:** ☐ **I do not give consent for:**

1. Transfer to the most accessible hospital, if needed. Hospital of preference:
2. Emergency medical treatment, as needed, by a licensed physician or dentist, and in the event emergency treatment is necessary, please contact: ***(Must list two contacts)***

| NAME | RELATIONSHIP | HOME PHONE# | CELL PHONE# | WORK PHONE# |
|---|---|---|---|---|
| | | | | |
| | | | | |

| MEDICAL TREATMENT INFORMATION | NAME | OFFICE PHONE |
|---|---|---|
| **Primary Physician:** | | |
| **Dentist:** | | |
| **Other:** | | |
| **Insurance Provider:** | Policy Number: | |

Sensitivity to heat/cold or other weather conditions ☐ Yes ☐ No (If yes, explain):

| ALLERGIES *(include allergies to medications):* | CURRENT MEDICATIONS: |
|---|---|
| | |

**Medical condition, disability or physical impairments (diabetes, heart disease, seizures, vision impairment, hearing impairment, etc.):**

**Additional Information - Is assistance needed for hygiene or health needs? Please explain.**

| | | | | | |
|---|---|---|---|---|---|
| **COMMUNICATION:** | ☐ Verbal | ☐ Non-Verbal | ☐ Uses Sign Language | ☐ Uses Gestures | |
| | ☐ Other communication devices | | | | |
| **MOBILITY:** | ☐ Without assistance | ☐ With assistance | ☐ With walker or cane | | |
| | ☐ Uses wheelchair | ☐ Uses wheelchair on outings | | | |

**BEHAVIOR SUPPORT PLAN:** ☐ **Yes- attach BSP** ☐ **No**

| BEHAVIORAL CONCERNS: | DIETARY INFORMATION/MEALTIME EQUIPMENT: |
|---|---|
| | |
| **EVACUATION CONCERNS:** | **SELF CARE:** |
| | |

Signature of Person Completing Form _____ Relationship _____ Date _____

Signature of Guardian or Individual _____ Date _____

**Greene County Board of Developmental Disabilities**
**245 North Valley Rd., Xenia, OH 45385**
**(937) 562-6500 / www.greenedd.org**

**Authorization for Use of Disclosure of Protected Health, Confidential Information and Photo Release**

**Re: _____ DOB: _____**

**I hereby authorize the following person or organization to exchange/give/receive/share/disclose/re-disclose specific health information regarding service delivery for the purpose of securing, coordinating, and/or providing services for the above named person. I hereby give the Greene County Board of Developmental Disabilities permission to use photographic or other visual images on television, billboards and or other forms of media or print including the internet.**

**Greene County Board of Developmental Disabilities**

**To the following person or organization:**

_____

**(Name of Person/Organization)**

**List information being requested in detail:**

_____

**Medical, Vocation, Habilitation and or Photographic information.**

**For the purpose of: Keeping team members abreast of supports and needs of the client. To help educate the public about programs the Board offers to people who have developmental or intellectual disabilities (use of photographic images only).**

**Unless earlier revoked, this authorization will expire on the 365th day of the signing or as otherwise specified _____ days.**

**(I may revoke this Authorization at any time by notifying the releasing organization/person in writing except to the extent that the releasing organization/person has acted on the authorization).**

**I understand that once this authorization is acted upon, the receiving party may be under no legal obligation to maintain the confidentiality of health information and could disclose it to another party.**

**I understand that the provision of health care services will not be affected if I do not sign this authorization form.**

***I DO NOT give permission to use photographic images of my child _____**

**(Signature of guardian/parent and date)**

**This release is not valid for information regarding drug abuse, alcohol abuse, and psychotherapy notes regarding sexually transmitted diseases. A copy of this release has been offered to the individual, parent/guardian:**

_____

**(Staff Signature)**

**Signature of Individual: _____ Date: _____**

**Signature of Parent/Guardian: _____ Date: _____**

**Signature of Personal Representative/Relationship, if applicable: _____ Date:_____**

MONTGOMERY COUNTY
BOARD OF DEVELOPMENTAL DISABILITIES SERVICES

# Consent for Publication of Personally Identifiable Information

As part of its advocacy efforts on behalf of people with developmental disabilities, the **Montgomery County Board of Developmental Disabilities Services** (MCBDDS) seeks to provide information to the public through various programs and activities, events, facilities, staff, and the individuals and families it serves.

Before **personally identifiable information** is shared, individuals (or their legal guardians) must consent to the release of said information, which may include – but is not limited to – their name, likeness, voice, work, personal or background information and achievements.

This consent form releases MCBDDS from any liability associated with violation of privacy, confidentiality, personal or property rights that individuals or their guardians have in connection with such materials. Consent also affirms that individuals or their guardians a) waive any right to approve said materials, and b) understand that their participation is voluntary, and will not lead to financial compensation of any type.

**The Montgomery County Board of Developmental Disabilities Services has my permission to use my/my child's name, likeness, voice, work, personal or background information and achievements for community awareness, news or promotional purposes. I understand that publication may encompass presentations as well as print and electronic vehicles, including websites, videos, news outlets, social media sites, and more.**

**In granting this consent, I release and hold harmless the Montgomery County Board of Developmental Disabilities, its agents and successors, from liability or harm that may result from the publication of such materials.**

**I understand that this authorization may be revoked or cancelled at any time (except to the extent that action has been taken in reliance on it) by notifying, in writing, the MCBDDS Communications Specialist at 5450 Salem Avenue, Dayton, OH 45426 or via e-mail at communityrelations@mcbdds.org.**

Printed name of individual who is the subject of the release: _____

**Individual Consent**

☐ **I GIVE CONSENT** ☐ **I DO NOT GIVE CONSENT**

I am of full age and am my own guardian. I have read this release or had it explained to me, understand its contents, and agree to allow MCBDDS to publish my personally identifiable information for a period of one year from the date specified below.

_____ _____

Signature of Individual Date

**Guardian Consent**

☐ **I GIVE CONSENT** ☐ **I DO NOT GIVE CONSENT**

I am the parent and/or legal guardian of the person or minor named above, and have the legal authority to execute the above release. I have read this release or had it explained to me, understand its contents, and agree to allow MCBDDS to publish the personally identifiable information for a period of one year from the date specified below.

_____ _____

Signature of Parent or Legal Guardian Date