



**TEXAS**

Department of Assistive  
and Rehabilitative Services

**Division for Rehabilitation Services  
Office for Deaf and Hard of Hearing Services**

### Camp SIGN Application for Campers

Complete this application and return it with the \$35 application fee to

Office for Deaf and Hard of Hearing Services  
PO Box 12306  
Austin, TX 78711

If you need help or have questions, contact us at  
(512) 410-1387 or 1-866-568-5176  
Fax: (512) 407-3299  
Email: [ann.horn@dars.state.tx.us](mailto:ann.horn@dars.state.tx.us)  
[www.dars.state.tx.us/dhhs](http://www.dars.state.tx.us/dhhs)

#### Applicant Application

Last name:		First name:		Birth date:	Age at camp date:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number:		Email address:	
School:		City:		Grade:	

Select from each of the following categories.

T-shirt (adult size): <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL <input type="checkbox"/> XXXL	Ethnicity (select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Status of hearing loss: <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Cochlear implant <input type="checkbox"/> Other (specify):	Method of communication: <input type="checkbox"/> American Sign Language <input type="checkbox"/> Signed Exact English <input type="checkbox"/> Sign Language <input type="checkbox"/> Oral <input type="checkbox"/> Other (specify):
	Race (select all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		

#### Parent or Guardian Information

Select one:    Parent    Grandparent    Guardian    Other (specify):

Last name:		First name:	
Address:		City:	State:    ZIP code:
Home phone:	Work phone:		Cell phone:
Pager number or pager address:		Email address:	

## Person to Contact in Case of Emergency

Name:	Phone number:	Relationship:
-------	---------------	---------------

## Medical Information

Select all that apply.

Diseases the applicant has had: <input type="checkbox"/> None <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Other (specify):	Chronic or recurring medical conditions: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Constipation <input type="checkbox"/> Ear infection <input type="checkbox"/> Fainting <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Seizures <input type="checkbox"/> Other (specify):	Known allergies: <input type="checkbox"/> None <input type="checkbox"/> Animals <input type="checkbox"/> Hay fever <input type="checkbox"/> Insect stings <input type="checkbox"/> Medications <input type="checkbox"/> Pollen <input type="checkbox"/> Plants <input type="checkbox"/> Other (specify):	Emotional or behavioral problems: <input type="checkbox"/> None <input type="checkbox"/> Attention deficit <input type="checkbox"/> Bedwetting <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Other (specify):
--	--	--	--

Does the applicant take medicine?

Yes     No

If yes, list medicines below:

Does the applicant have behavior problems?

Yes     No

If yes, select all that apply.

- Temper tantrums
- Hitting others
- Disobeying
- Uncooperativeness
- Attention deficit
- Other (specify):

**Note:** Any camper who becomes a continual problem at the camp site will be sent home.

## Income Reporting

List the average monthly income for each member in the household, including children. Report gross income (amount before taxes, insurance, or deductions). You may choose to not provide the income information. If so, you must pay the full camp fee plus the application fee for your child. The amount due is listed in the preacceptance letter.

If you do not wish to list the income information and agree to pay the full camp fee for this camper, enter or print your initials here: \_\_\_\_\_

First name	Last name	Social Security number*	Monthly income
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

\*If any member of the household receives food stamps or Temporary Aid to Needy Families (TANF), list his or her case number and Social Security number.

## Signature

By signing this form, I affirm that

- I am providing true and correct information regarding my child or foster child;
- I am applying to Camp SIGN for my child or foster child. I am submitting a nonrefundable application fee of \$35.00. I understand that I will be charged and held responsible for any fees incurred by checks submitted with insufficient funds;
- I agree to release and hold harmless DHHS Camp SIGN from any damages arising out of personal injury or sickness caused by any accident occurring on or off the camp premises;
- I give permission to DHHS Camp SIGN officials to provide any and all medical attention to my child in the event of injury or sickness;
- I give permission for DHHS Camp SIGN to photograph, use, and release photographs of my child for the purpose of publicizing and promoting Camp SIGN;
- I understand that complete cooperation is expected from my child or foster child; and
- I understand that I am responsible for transportation to and from the camp for my child or foster child.

Signature of parent or guardian:

Date:

Printed name: