

# Arizona Magic of Music & Dance

is proud to present our  
summer theater camp  
2011

## Once Upon A Time

A compilation of songs and scenes from several of your child's  
favorite movies including;

*Snow White, Aladdin, Cinderella, and Sleeping Beauty*

**June 6 to 10<sup>th</sup>**  
9:00AM to 3:00 PM

Christ's Church  
15555 E. Bainbridge Ave.  
Fountain Hills, AZ 85268

Children and young adults with any level of disability, age 8 and above, are invited to attend this magical day camp with activities and rehearsals designed to encourage fun and confidence. Teen buddies cheer on your child during rehearsals, games and art activities which can all be adapted for your child's specific needs. Snacks and lunches shared together are provided daily. The final stage presentation, complete with costumes and scenery, will be Friday the 10<sup>th</sup>. Be sure to come with family and friends to watch your child discover "magical possibilities"!

Only 25 actor spots are available, so register your child soon. Cost of camp is \$395. Download registration forms at [www.azmagic.org](http://www.azmagic.org) and return with **\$25 deposit** payable to **ZETA21 International**. Please send to the address below.

**Celeste Kaseburg**  
**PO Box 9471**  
**Surprise, AZ 85374**

Your deposit will be deducted from the total camp fee with the remaining balance be due by May 25th. If you would like more information, please contact Celeste at 480-296-3034 or [celeste@azmagic.org](mailto:celeste@azmagic.org).



*Magical Possibilities for Youth with Disabilities*

**ARIZONA MAGIC OF MUSIC & DANCE - PARTICIPANT INFORMATION SHEET**

Please fill out the application completely and accurately

Arizona Magic of Music & Dance recommends you consult a physician before participating in the program

Participant Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ T-Shirt Size \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.  
\_\_\_\_\_  
\_\_\_\_\_  
Medical Alert: \_\_\_\_\_  
Email: \_\_\_\_\_

**PARENT/GUARDIAN**

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Name: \_\_\_\_\_ Location: \_\_\_\_\_  
Office Phone: \_\_\_\_\_

Dietary Restrictions (if any) \_\_\_\_\_

Please state disability: **(Be Specific)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What, if any, assistive equipment does your child use: \_\_\_\_\_

\_\_\_\_\_

Has your child had any seizures in the past 2 years? \_\_\_\_ Yes \_\_\_\_ No

Frequency/detail: \_\_\_\_\_

*(The following categories pertain to specific disabilities. Please complete the section that most describes disability.)*

**ATTENTION DEFICIT DISORDER**    \_\_\_ ADD    \_\_\_ ADHD

Does your child take medication for ADD?    \_\_\_ Yes    \_\_\_ No    How often? \_\_\_\_\_

**VISUAL IMPAIRMENT**    \_\_\_ Partially Sighted/Legally Blind    \_\_\_ Totally Blind

\_\_\_ Cataracts    \_\_\_ Retinopathy    \_\_\_ Glaucoma    \_\_\_ Diabetes

\_\_\_ Optic Atrophy    \_\_\_ Congenital    \_\_\_ Trauma    \_\_\_ Macular Degeneration

\_\_\_ Retinitis Pigmentosa    \_\_\_ Other (explain)

Amount of vision (i.e. peripheral, tunnel, light and dark, etc.): \_\_\_\_\_

**HEARING IMPAIRMENT**

Does your child have difficulties hearing?    \_\_\_ Yes    \_\_\_ No

If yes, please explain: \_\_\_\_\_

**OTHER**

Does your child have difficulty speaking or communicating?    \_\_\_ Yes    \_\_\_ No

If yes, please explain: \_\_\_\_\_

Does your child have any learning disabilities (i.e. following instructions, reading, processing sensory input, etc.)?    \_\_\_ Yes    \_\_\_ No

If yes, please explain: \_\_\_\_\_

Does your child have any physical disabilities (i.e. low muscle tone, poor hand-eye coordination, etc.)?    \_\_\_ Yes    \_\_\_ No

If yes, please explain: \_\_\_\_\_

Please describe your child's specific challenge or disability: \_\_\_\_\_

Do you have a buddy preference? Male \_\_\_ Female \_\_\_

**CURRENT MEDICATIONS**

Will your child be taking medications at camp?     Yes     No

Medication	Dosage	Schedule	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies (if any): \_\_\_\_\_

Do we have your permission to share your email with your new friend from camp? YES \_\_\_\_\_ NO \_\_\_\_\_

**Publicity Release**

This release grants or denies **Arizona Magic of Music & Dance** from using persons in photographs, audio, video or electronic imagery to further the charitable and educational purposes of **Arizona Magic of Music & Dance**, and the advancement of the interest of children and young adults with physical and mental disabilities, through, but not limited to, television, newspapers, websites, radio, and agency generated publicity formats of the person mentioned below, engaged in the activities and events sponsored by **Arizona Magic of Music & Dance**.

**CHECK ONLY ONE:**

\_\_\_\_\_ I, the undersigned parent and/or guardian **GRANT** permission for my child to be in manners listed above for publicity and educational purposes.

\_\_\_\_\_ I, the undersigned parent and/or guardian **DO NOT GRANT** permission for my child to be used in manners listed above for publicity and educational purposes.

**I have read and I understand the above set arrangement with Arizona Magic of Music & Dance.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



**Arizona Magic of Music & Dance**  
*"Magical Possibilities for Youth with Disabilities"*

**Your child will be working with a teen volunteer buddy during the week of camp, under the supervision of adult camp personnel and volunteers. In order to for us to match the best teen with your child, please give us some information. Your complete answers will help us make it the most enjoyable camp experience for all.**

1) Does your child need any hands on assistance or prompting with any of the following (If so, please describe)

- Feeding, cutting food, opening packages
- Washing hands or face
- Toileting
- Dressing or changing into costume
- Reminders to stay on task
- Cutting, drawing, writing

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Is your child bothered by any situations, if so please describe and tell what helps in these situations.

- Loud noises or other sounds
- Crowded areas or
- Bright or blinking lights
- Tactile like paint on hands, stickers, etc.
- Hats on head or other accessories
- Schedule oriented
- Other

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Many of our actors are verbal but some need assistance with cues to help verbalization and comprehension. How does your child communicate?

- Verbal
- Non Verbal
- Picture Cues
- Signing
- Communication Device, Big Macs, Step Up Switches, Rocker Plate Switch
- Are there any accommodations we should make?

Describe: \_\_\_\_\_

\_\_\_\_\_

- Does your child follow directions easily or are there ways to help him/her understand?  
Example: picture cues, lists, time charts

Describe: \_\_\_\_\_

\_\_\_\_\_

4) If your child becomes upset or bothered by something, what strategies work best to help? Example: offer reward, quiet time, a favorite object, music, etc.

5) For building buddy interaction, let us know what interests your child - favorite songs or musical artist, favorite pets, TV shows, movies, favorite color/s, favorite place, best friend.

6) Would it be helpful and enjoyable for your child to have two buddies assigned or would they feel more independent with just one?

7) Please list any allergies to food:

8) Please list any allergies to other:

**Arizona Magic of Music & Dance** will permit administration of either prescription or non-prescription medication to enrolled actor by the Program Manager or a designated staff member. Prescription must be provided in a container dispensed by a pharmacy. Non-prescription medication must be provided in its original manufacturer container labeled with the child's name.

Medication: \_\_\_\_\_

Prescription number: \_\_\_\_\_

Dosage (amount to be given): \_\_\_\_\_

Route (by mouth, etc.): \_\_\_\_\_

How often or at what time is the medication to be given?

\_\_\_\_\_

Reason for medication: \_\_\_\_\_

\_\_\_\_\_

10) **In addition**, If my child becomes ill during the program, I authorize the Program Manager or a designated staff member to give the following over the counter medications as needed. I understand that the Program Manager will contact me and inform me if this happens.

**Please specify the dosage of the ones that can be given:**

Tylenol  
Dosage \_\_\_\_\_

Advil  
Dosage \_\_\_\_\_

Benadryl  
Dosage \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**Please send forms back to:  
Celeste Kaseburg  
PO Box 9471  
Surprise, AZ 85374**