

A  
S  
S  
E  
S  
S  
M  
E  
N  
T

# Camp Holiday Trails

A Camp for Children with Special Health Needs



400 Holiday Trails Lane  
Charlottesville, VA 22903  
Ph. (434) 977-3781  
Fax (434) 977-8814

[campisgood@campholidaytrails.org](mailto:campisgood@campholidaytrails.org)  
[www.campholidaytrails.org](http://www.campholidaytrails.org)

## CAMPER ASSESSMENT

*(To be completed by Social Worker, Guidance Counselor, Therapist or Teacher)*

**ALL INFORMATION IS CONFIDENTIAL**

The person who asked you to complete this form is applying to attend Camp Holiday Trails. Camp Holiday Trails is a very special place that gives children with chronic illnesses and special medical needs the chance to experience a traditional camp. Our Med Staff work 24 hours a day in an on-site clinic and we have one adult counselor for every three campers. In all other respects, Camp Holiday Trails is a traditional summer camp, with all the outdoor summer activities children love – and opportunities to develop self-confidence, build self-esteem, foster independence and better manage their healthcare.

**Campers should function cognitively within 1 or 2 years of their actual age** and be, for the most part, independent. Your cooperation and accuracy with the completion of this form will ensure a positive camp experience for all of our campers and will enable the camp to make an appropriate individualized assessment of the applicant's abilities.

**Please mail or fax this form directly back to Camp Holiday Trails ASAP. Thank you!**

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade \_\_\_\_\_

In what capacity do you know this child? \_\_\_\_\_

How long have you known this child? \_\_\_\_\_

How often do you see this child? \_\_\_\_\_

Describe your interactions with this child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does this child respond to limits or directions from you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From others? \_\_\_\_\_

\_\_\_\_\_

How does this child view his/her overall health? \_\_\_\_\_

\_\_\_\_\_

Camper Name: \_\_\_\_\_

What have you observed of this child's ability to care for his/her medical condition? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this child exhibit any fears or phobias? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note any behavior concerns you may have about this child:  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does this child interact with his/her peers? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you observed emotional outbursts from this child? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Overall, do you consider the applicant to be:  
\_\_\_\_\_ emotionally immature \_\_\_\_\_ shy  
\_\_\_\_\_ mature \_\_\_\_\_ outgoing  
\_\_\_\_\_ age appropriate

Is this child developmentally appropriate for his/her age?  YES  NO  
If NO, at what (approximate) age does the child function: \_\_\_\_\_

What role can we play in fostering or increasing this child's sense of independence? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you recommend this child for a **residential/overnight camp experience**?  
Yes, absolutely \_\_\_\_\_ Yes, with some reservation \_\_\_\_\_ Possibly \_\_\_\_\_ No \_\_\_\_\_  
If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please provide us with any additional pertinent information regarding this child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Your attention and detail in completing this assessment will make a tremendous difference in the Camp experience for this child - thank you!***

**RETURN TO:**

400 Holiday Trails Lane, Charlottesville, Virginia 22903 ▪ Phone: (434) 977-3781 ▪ FAX: (434) 977-8814  
campisgood@campholidaytrails.org ▪ www.campholidaytrails.org