



**Pennwood Adult Vacation Experience  
The Arc of York and Adams Counties  
June 15-19, 2026**

**2026 P.A.V.E. APPLICATION**

**I. GENERAL INFORMATION: (Please Print)**

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

**Emergency Contact:** (Person familiar with camper, available from 10:00 AM - 3:00 PM)

(Name) \_\_\_\_\_

(Telephone) \_\_\_\_\_

**COSTS AND FUNDING:**

The Adult Camp Pennwood fee is \$390.00, payable at the time of application. MH-IDD funding may Apply.

**DEADLINES**

**Please complete and return all forms and payment by May 1, 2026.**

(Application, Release Form, Health Exam Form, Medical History Form, Confidential Household Survey)

**Send your application to:**

Alicia Zienkiewicz  
The Arc of York and Adams Counties  
497 Hill Street  
York, Pa 17403

- Please note that registrations will be accepted on a first-come, first-served basis and that the number of registrations may need to be limited.

## **II. INDIVIDUAL SKILLS DEVELOPMENT:**

To help us provide you with the most enjoyable summer possible, please describe in detail the following information about your needs:

**Toileting** (assistance with clothes or toileting/ Depends, constant supervision, independent, etc.)

**Personal hygiene** (washing hands, combing hair, menstrual care, etc.)

**Dressing** (buttons, zippers, putting clothes on, etc.)

**Eating** (physical assistance, utensils used, special diet, etc.)

**Communications skills** (non-verbal, sign language, language board, etc.)

**Interactions with other adults** (gets along well, fights, shy, etc.)

**Behaviors** (wanders off, easily upset, short attention span, etc.)

**Aggressive behaviors and preventive techniques** (hitting, biting, destroying property, etc.)

**Activities: Sports, Arts and Crafts, Music** (favorites, dislikes, needs, etc.)

**Swimming skills** (no experience, afraid of water, previous lessons, needs, etc.)

**Allergies/Food Restrictions**

**Transfer Skills** (if utilizing a wheelchair)

**Did we miss anything?** (Please include anything you think we should know.)

**HEALTH EXAMINATION  
BY LICENSED PHYSICIAN  
FOR P.A.V.E.  
Pennwood Adult Vacation Experience**

I \_\_\_\_\_ authorize my physician to provide the following information. I understand that it will be used only by The Arc of York and Adams Counties' staff to help me during camp.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All information is to be completed by a licensed physician.**

I have examined the above applicant within the past twelve months.

Date of Exam: \_\_\_\_\_

Is the applicant free of infectious disease? \_\_\_\_\_ YES \_\_\_\_\_ NO

If no, please indicate type of disease: \_\_\_\_\_

Medication(s) prescribed: \_\_\_\_\_

Please list any medications that will need to be administered during P.A.V.E. (10 a.m.-3 p.m.)  
\_\_\_\_\_  
\_\_\_\_\_

Are there any medical reasons why this patient should not attend an outdoor day camp with field trips in the community?  
\_\_\_\_\_

Identify any medical problems that may place this applicant at an increased risk of medical emergency:  
\_\_\_\_\_  
\_\_\_\_\_

In my opinion, this condition **does/does not** preclude his/her participation in an active camp/community activity.

**Health History** (Circle if applicant has had any of the following):

Asthma/Breathing Difficulties	Heart Disease	Convulsions/Seizures	Hepatitis
Bleeding/Clotting Disorder	Diabetes	Hypertension	Tuberculosis
Other _____			

**Allergies:**

Hay Fever	Poison Ivy	Insect Stings
Penicillin	Other Drugs	

Please explain if needed:  
\_\_\_\_\_  
\_\_\_\_\_

Operation or serious injuries (please explain):

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Disability or chronic or recurring illness:

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The applicant is currently under the care of a physician for the following conditions:

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Instructions for management of applicant's seizure disorder (if applicable):

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Current treatment (include medications and dosages):

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Please list any orthotics or prosthetics which may be necessary at camp. List any special instructions required to use them properly.

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Describe any prescribed meal plan or dietary restrictions:

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Identify any allergies or asthma and proper treatment if individual experiences acute condition:

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Date of last tetanus shot: \_\_\_\_\_

From completed by Dr. \_\_\_\_\_  
(Please type or print)

Licensed Physician's signature: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Date form completed: \_\_\_\_\_

## RELEASE FORM

**CAMPER'S NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

### PHOTOGRAPHY CONSENT

I hereby grant permission for the staff of The Arc of York and Adams Counties or its designated representative to photograph me while participating in the daily activities of P.A.V.E. These photographs may be used for publicity for The Arc of York and Adams Counties in its newsletter or annual calendar or in the newspaper or other media.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### TRANSPORTATION CONSENT

I hereby grant permission to be transported on field trips in a van provided by Kelly Transit during PAVE.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### LEGAL CONSENT

Absent gross negligence or wrongdoing by The Arc of York and Adams Counties, I hereby release The Arc of York and Adams Counties, the Board of Directors and its individual members, P.A.V.E., its staff, counselors, volunteers, and any and all persons who assist in taking charge of the program and activities from any and all liability or claim arising from the accidental injury to, or death of me, incurred during or in transit to or from my participation in programs and activities from any cause whatsoever.

I further waive claim on The Arc of York and Adams Counties for any loss or damage to my property, whether in the program or en route to and from the program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**I have witnessed the signing of these releases.**

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**The Arc of York and Adams Counties**  
**MEDICAL HISTORY FORM**  
**P.A.V.E.**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_  
**DENTIST'S NAME:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**Do you have medical/hospital insurance?** \_\_\_\_\_ If so, please indicate:

Carrier: \_\_\_\_\_ Policy or Group # \_\_\_\_\_  
PA Medical Assistance Card (formerly ACCESS): \_\_\_\_\_  
ID #: \_\_\_\_\_ PCS #PACs: \_\_\_\_\_

While attending P.A.V.E., I give permission to staff to use their own judgment in administering the following if needed:

\_\_\_\_\_ Tylenol \_\_\_\_\_ (indicate amount)  
\_\_\_\_\_ Advil \_\_\_\_\_ (indicate amount)  
\_\_\_\_\_ Benadryl \_\_\_\_\_ (indicate amount)  
Triple Antibiotic ointment  
Galadriel lotion  
Other \_\_\_\_\_ (indicate amount)

**IMPORTANT -- THIS BOX MUST BE COMPLETED FOR ATTENDANCE**

**DAILY ADMINISTRATION OF MEDICATION/EMERGENCY AUTHORIZATION:**

I give permission to personnel selected by the P.A.V.E. Coordinator to administer medication at my request and to apply routine first aid as needed.

I give permission for a physician to hospitalize, order x-rays, routine tests, and/or secure proper Treatment for me.

I certify that this health information, which I have supplied, is accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**The Arc of York and Adams Counties**  
**497 Hill Street**  
**York, PA 17403**  
**(717) 846-6589**

***THANK YOU FOR PARTICIPATING IN PROGRAMS OFFERED BY THE  
ARC OF YORK AND ADAMS COUNTIES.***

1. We hope that you will be happy with your services. Despite all our efforts, there may be times that you do not agree or are unhappy with something about your services.
2. The Arc has a grievance policy -- which means that you can have your complaint reviewed by the appropriate Arc supervisor.
3. If you have a grievance, please ask for a grievance form. Assistance will be made available to complete the complaint process if needed.
4. When you have a formal complaint or grievance, it is The Arc's obligation to get back to you within one week. If more time is needed, The Arc supervisor is to call you to explain the delay and to tell you when to expect to hear from them.
5. If you are still unhappy and your complaint has not been resolved, you can file a grievance with MH/MR, OVR, or the organization which is funding your services.

**THIS NOTICE IS TO BE PROVIDED TO ALL PROGRAM PARTICIPANTS BY THE DIRECT SERVICE PERSONNEL. IT IS TO BE EXPLAINED AND LEFT WITH THE PERSON(S) WHO WILL BE RECEIVING SERVICES OR THE GUARDIAN OR CARE-GIVER OF THE PERSON.**



## HOUSEHOLD SURVEY

The Arc of York and Adams Counties receives contributions and funding from many sources, including the United Way and the County of York. They have requested that we collect the following information. It is not mandatory for you to complete this form, but it will be appreciated, as it will help The Arc receive much needed funding.

Please check the gender of the person (s) who will receive services through The Arc of York and Adams Counties.

Female  Male  Other

Please check the age range of the person (s) who will receive The Arc of York County services.

0-5  6-12  13-24  25-39  40-59  60+

Please check the race or ethnic background of the person (s) who will receive The Arc of York and Adams Counties services

You may check more than one.

White (not Hispanic/Latino)  
 African American/Black  
 Latino/Hispanic Origin  
 Other

Asian  
 Hawaiian/Pacific Islander  
 American Indian or Alaska Native  
 multi-race

What is your total yearly income from wages or salary, self-employment, social security, pension, public assistance, rent, interest, or other sources? (Check one line only)

Unemployed  \$ 25,000-\$49,999  
 Less than \$15,000  \$50,000-\$74,999  
 \$ 15,000-\$24,000  Over \$74,000

Please indicate your Zip Code. \_\_\_\_\_

Name of individual receiving services: \_\_\_\_\_  
Address: \_\_\_\_\_

Signature of person completing form (not required) \_\_\_\_\_

Please complete this form and return it to The Arc at this address:

Dept \_\_\_\_\_

The Arc of York and Adams Counties  
497 Hill St.  
York, Pa. 17403

**This information will be kept strictly confidential. Thank you.**

## **Rights of the Individual**

- (a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.
- (b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, practice the religion of the individual's choice and practice no religion.
- (c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.
- (d) An individual shall be treated with dignity and respect.
- (e) An individual has the right to make choices and accept risks.
- (f) An individual has the right to refuse to participate in activities and services.
- (g) An individual has the right to control the individual's own schedule and activities.
- (h) An individual has the right to privacy of person and possessions.
- (i) An individual has the right of access to and security of the individual's possessions.
- (j) An individual has the right to choose a willing and qualified provider.
- (k) An individual has the right to choose where, when and how to receive needed services.
- (l) An individual has the right to voice concerns about the services the individual receives.
- (m) An individual has the right to assistive devices and services to enable communication at all times.
- (n) An individual has the right to participate in the development and implementation of the individual plan.
- (o) An individual and persons designated by the individual have the right to access the individual's record.

Individual Name: \_\_\_\_\_  
(Please print)

Individual Signature: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_  
(Please print)

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_