Kidz in Motion - For Clinicians and Other Participants August 12-16, 2019

OT For Kidz is now welcoming back their 1 week (5 day) summer program. This program combines an exciting "camp-like" environment with an intensive sensory integration treatment approach for children ages 4-11 with special needs. Children participate in a broad range of fun-filled activities designed to have a therapeutic benefit. This is combined with occupational therapy utilizing the sensory integration theory and other neuro-behavioral strategies with the underlying understanding of plasticity of the brain. A limited number of applicants who are interested in participating will have the opportunity to experience hands-on learning using many dynamic strategies for working with children with special needs. Practical hands-on learning time combined with formal learning time together average 8 hours per day in additional to orientation training. Participants who are Occupational therapists and occupational therapy assistants will be eligible to receive 41 contact hours/.41 AOTA CEUs, other clinicians or educators 41 contact hours and students 41 volunteer hours. *NYSOTA Approved CE workshop* NYSOTA New York State Occupational Therapy Association

Orientation/Training Date: 8/10/19 RATE: Clinicians/Professionals Early Bird Rate $199/ Regular Rate $249; Students Free

Target Participants for Counselors: OT, COTA, PT, PTA, Speech Therapists, Teachers, other Pediatric Clinicians and Educators
Educational Level: Beginners-Advanced
Target Participants for Counselor Assistants: College Students in the field of Healthcare and/or Education

Learning Objectives:

1. Identify and demonstrate administering at least 1 standardized tool, through hands-on practical (BOT2)
2. Identify various sensory-based methods and strategies that may be used with children with special needs with diagnosis such as SPD, ASD, ADHD, LD and DD
3. Identify and differentiate between deficits in sensory processing affecting children's functional skills
4. Identify how to integrate sensory integrative concepts into a treatment protocol for children such a w/SPD, ASD, ADHD, LD, DD
5. Identify, List and demonstrate supportive strategies that may be used in your treatment regime

Most of the children may have mild to moderate learning disabilities, sensory processing disorders, ASD, ADHD and/or other developmental disorders that may be impacting their learning, ability to focus, motor, communication and/or social skills. All children will be ambulatory and toilet trained between the ages of 4-10. Participants will be able to work hands-on with the children. Each participant will be presented with opportunities to enhance professional development and skills within the framework of the child's goals and the mission of Kidz in Motion. **Our Mission** is to provide a treatment environment in the context of a fun filled "camp-like" experience to children with special needs. Participants will be assigned children with a ratio of 1:1 or 1:2 depending on the child. The participants along with OT For Kidz staff will collaborate to plan appropriate activities for each child and ways to make the child's experience a positive and therapeutic one. The daily regime consists of facilitating various structured sensory-based activities which will take place on-site at OT For Kidz as well as off-site. On-site activities include brain based exercises/activities (i.e. iLs, SMART, therapeutic massage,etc) and off-site activities include (therapeutic horse riding, aquatic activities, bounce house activity) to improve children's cognitive, social and/or motor skills. Breakfast & lunch will be provided daily for the participants.

Participants learning experiences will be facilitated by Paula Stewart, MS,OTR/L and Christine Grant, MS, OTR/L who are also the owners of OT For Kidz. Both Paula and Christine are both occupational therapist with over 20 years of clinical experience. They are SIPT certified clinicians which is an advanced national certification in the evaluation and treatment of Sensory Processing Disorders (SPD). Both have been trained in treating auditory processing deficits (usually part of a greater sensory processing disorder) using iLs (Interactive Listening Systems), IM (Interactive Metronome) or the Therapeutic Listening Program. They incorporate their training in Reflex Integration, Therapeutic Handling & Massage, neuronet and Oculo-motor/functional vision along with many other strategies into their treatment sessions and these are integrated into the Kidz in Motion Program.

If interested please contact us at: 718-949-5439 (office) 646-302-6709 (Paula) 917-478-7388 (Christine)
or email us at www.Occupationaltherapy4kidz@gmail.com Visit www.occupationaltherapy4kidz.com

KIDZ IN MOTION

REGISTRATION APPLICATION

NAME (PLEASE PRINT) : _____

HOME ADDRESS: _____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

POSITION (must be a licensed/registered clinician): ☐**OT/Counselor** ☐**COTA/Counselor** ☐**ST/Counselor** ☐**PT/Counselor**

☐**Other Discipline/Counselor** (please name discipline): _____

☐ **College Student/Assistant Counselor**

(Must be in an approved OT or OTA program) **Major:** ☐**OT** ☐**COTA** **1st** yr Student __ **2nd** yr Student __ **3rd** yr Student __ **4th** yr Student__

(Must be in an approved discipline specific program or a graduate) ☐**Other Major** (please be specific major & year status) : _____

Please submit attached to your application and check all that apply:

☐ I have a copy of my resume to submit

☐ I have a copy of an updated professional license to submit

☐ I have a copy of proof of student status (i.e. transcript or other proof) to submit

☐ I have been fingerprinted by the following (please specify) Dept. of Education ___ Dept. of Investigation ___

☐ I have a copy of my professional liability insurance to submit

☐ I have a copy of an updated medical which includes PPD shots to submit

☐ I agree to have a background check completed by OT For Kidz [please fill out form on next page(s)]

☐ I have a copy of 2 letters of references (professional or personal)

☐ I acknowledge that my participation may include contact with horses, participation in aquatic activities as well as other physical activities. I also acknowledge that I must complete the entirety of this program to receive full credit towards contact hours, AOTA CEUs and/or volunteer hours.

Additional Certification (i.e. First Aid, CPR, etc): _____

OTHER INFORMATION:

What do you hope to learn from this experience (state goals): _____

_____

_____

Special Skills/Talents (i.e. yoga, dance, etc): _____

T-shirt Size: Small _____ **Medium** _____ **Large**_____ **Extra Large**_____ **Other** _____

_____

Signature (By signing, I attest that the completed information is accurate)

Hand in application in-person, Email to Occupationaltherapy4kidz@gmail.com or fax to 718-949-5438

OT For Kidz thank you for your inquiry to participate in our Summer Program, **Kidz in Motion**! Because we get an overwhelming amount of inquiries, unfortunately, all students may not be to register for the counselor assistant position. We will make every attempt to accommodate all. However, we may have positions available as an onsite **Program Support Assistant**. Students in this position will also earn volunteer hours and a certificate of completion. Please include this page when submitting your application.

Program Support Assistant

Responsibilities: Attend all 5 days of the summer program in August 2018. The Program Support Assistant will help prepare for program activities, organize materials, assist in managing communications between parents, counselors, and the directors, give feedback and support in way necessary to help make the program run smoothly.

Target Participants for Program Support Assistant: Preferable College Students in the field of Healthcare and/or Education

Learning Opportunity includes but not limited to

1. Assisting in scoring at least 1 standardized tool
2. Organize and set up for various activities related to program
3. Participate in orientation/in-service geared towards identifying and differentiating between deficits in sensory processing affecting children's functional skills
4. Participate in orientation/in-service geared towards identifying how to integrate sensory integrative concepts into a treatment protocols for children such a w/SPD, ASD, ADHD, LD, DD
5. Observation opportunity and provide assistance with on-site activities and provide support for the program

Please check 1 box

☐ I **prefer** the Counselor Assistant position and my 2nd choice would a Program Support Assistant position

☐ I **prefer** the Program Support Assistant and my 2nd choice would be as a Counselor Assistant position

☐ I'm **NOT** interested in the Program Support Assistant Position

August 12-16, 2019 (Monday-Friday)
Occupational Therapy For Kidz, Specializing in Sensory Integration
219-02 Linden Blvd, Cambria Heights, NY 11411
Time of Program: 7:30 am - 4:30 pm
Orientation 8/10/19 12-4 pm **(corrected date)**

LDSS-3370 (Rev. 04/2011) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
HA4	20915323		Y	(718)949-5439

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: Occupational Therapy For Kidz Specializing In Sensory Integration, LLP

AGENCY LIAISON: Paula Stewart

STREET ADDRESS 219-02 Linden Blvd

CITY: Cambria Heights **STATE:** NY **ZIP CODE:** 11411

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE

APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE

SIGNATURE	DATE

LDSS-3370 (Rev. 04/2011)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To