Led by our pediatric occupational therapists, Power Play is a multi-week program that focuses on improving upper extremity function in children who have spastic hemiplegia or hemiparesis as a result of cerebral palsy, traumatic brain injury, stroke or other diagnoses.

This program utilizes principles from a modified Constraint Induced Movement Therapy (CIMT) protocol, in which the unaffected arm is restrained by a removable cast and the affected arm is used for all functional activities.

Camp activities include games, art projects, outings, sensory play activities, bimanual activities and self care. Children will be evaluated at the beginning and end of camp to progress in strength, flexibility and use of the affected arm can be measured.

A physician referral/prescription is required to participate in the camp. Participants must have an insurance policy that will cover group therapy.

Ages 2–3
Monday, Tuesday & Wednesday
June 22–July 1
10 am–12 pm

Ages 4–6
Monday–Thursday
July 20–August 6
8:30–11:30 am

Ages 7–10
Monday–Thursday
July 20–August 6
1–4 pm

Participants must be:
• Ambulatory
• Able to grasp and release an object

To sign up, contact us at 312.238.1139 or pedscamps@sralab.org
Please print and complete all entries

Patient Name: ___________________________  Patient Birth Date: ___________________________

Address: ____________________________________________________________

Home Phone: _________________  Cell Phone: _________________  Email: ____________________________

Primary Doctor/Pediatrician : ___________________  Ordering Physician (for camp):______________________

Emergency Contact: _________________  Relationship: _________________  Phone Number: _____________

Insurance Information

Insured/Responsible Party: ___________________________  Relation to Patient:_________________________

Birth Date: _____________  Address (if different from patient):________________________________________

Primary Insurance: _________________________  Address: __________________________________________

Phone Number:________________  Group Number: __________________  ID Number:__________________

Secondary Insurance: _________________  Address: _______________________________________________

Phone Number:________________  Group Number: __________________  ID Number:__________________

Additional Information

Is the patient currently receiving occupational therapy (OT)?

Has the patient done CIMT before?

Please list patient’s interests and hobbies:

How did you learn about our camps?