

# Power Play

## 2020 Pediatric CIMT Summer Camp



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

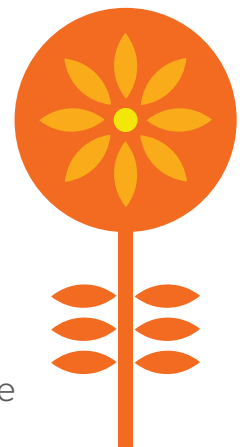
Monday–Thursday  
July 20–August 6  
8:30–11:30 am

### Ages 7–10

Monday–Thursday  
July 20–August 6  
1–4 pm

### Participants must be:

- Ambulatory
- Able to grasp and release an object



Shirley Ryan  
**Abilitylab**

To sign up, contact us  
at 312.238.1139 or  
[pedsamps@sralab.org](mailto:pedsamps@sralab.org)

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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?

