# INDIVIDUAL APPLICATION

421 WEAVER MILL ROAD, RECTOR, PA 15677 ▪ **PHONE:** 724-238-2400 ▪ **FAX:** 724-238-4400
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Please complete the following information and **HAVE A PARENT/GUARDIAN AND THE CHILD SIGN in the appropriate SIGNATURE blanks below**. Please attach a photocopy (front and back) of the camper's health card. **Your child must have adequate medical coverage to attend camp!**

Are you a... ☐ **Camper** ☐ **Kaleo**

Have you attended SB2W camp(s) have before? **YES** ☐ **NO** ☐
If so, which? **CITIKIDZ** ☐ **LG** ☐ **QUE** ☐ **DAY CAMP** ☐

Are you already on a camp team? **YES** ☐ **NO** ☐ **ROMAN** ☐ **GALATIAN** ☐

Name: First | Middle | Last  Session#:  Application Year: **2019**

Home Address: Street | Apt #  Age  Home Phone:

City:  State:  Zip:  Birth: Month/Day/Year  Eye Color:  Sex:

E-mail:  High School: (if applicable)  Grade Level:  Grade Point Avg:

Father/Guardian Name:  Work Phone:  Expected HS Graduation Year:

Mother/Guardian Name:  Work Phone:  Favorite Sport:

Group Leader:  Group Name:

Race/Ethnic Background:  Primary Coach/Mentor:  Coach/Mentor Email:

☐ Check this box if you have a sister or brother in camp with you this session. Write the first and last name(s) of each sibling in the spaces provided below:

| First | Last | First | Last | First | Last | First | Last |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## EMERGENCY INFORMATION

**In case of an emergency, please notify:** (please provide area codes)

Name:  Relationship:  Phone:

Name:  Relationship:  Phone:

## HEALTH HISTORY

| Has your child had any of the following? | YES | NO | Approximate Date of Ailment |
|---|---|---|---|
| Chicken Pox | ☐ | ☐ | |
| Measles | ☐ | ☐ | |
| Mumps | ☐ | ☐ | |
| Pregnancy | ☐ | ☐ | |
| Sickle Cell Anemia | ☐ | ☐ | |
| Whooping Cough | ☐ | ☐ | |

## ALLERGIES

| | | | | | |
|---|---|---|---|---|---|
| Hay Fever/Seasonal | ☐ Yes | ☐ No | Food | ☐ Yes | ☐ No |
| Insect Bites/Stings | ☐ Yes | ☐ No | Meds | ☐ Yes | ☐ No |
| Wildlife (poison ivy, poison oak) | ☐ Yes | ☐ No | *Epipen must be provided, if necessary. | | |

**Please specify other allergies or allergies to *medication*:**

**Please specify *food* allergies:**

## HEALTH CONCERNS

- ☐ ADD/ADHD
- ☐ Asthma (require inhaler)
- ☐ Athlete's Foot
- ☐ Bedwetting
- ☐ Constipation
- ☐ Corrective Lenses
- ☐ Dental Appliances
- ☐ Diabetes
- ☐ Ear Infections/Concerns
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Frequent Sore Throats
- ☐ Glasses/Contact lenses
- ☐ Headaches
- ☐ Heart Disease/Concerns
- ☐ Hemophilia
- ☐ Kidney Concerns
- ☐ Nose Bleeds
- ☐ Seizures or Convulsions
- ☐ Sickle Cell (trait only)
- ☐ Sleepwalking
- ☐ Upset Stomach
- ☐ Other

**Mark all that apply**

**Please explain any of the above "Yes" items, as well as identify operations, serious injuries, or fractured bones:**

**Insurance Company:**_____ **Date of last physical exam** _____ **Are all immunizations up to date?** _____

**Policy Holder's Name& DOB:**_____ **Relationship to Applicant:**_____**Exp Date:**_____

**Medicaid Number:**_____ **State Issued In:**_____**Exp Date:**_____ **Date of last tetanus booster** _____

****PLEASE ATTACH A COPY OF YOUR CHILD'S PROOF OF INSURANCE TO THIS FORM****

If your child has seen a doctor or been hospitalized in the past three years other than the operations, serious injuries, or fractured bones previously mentioned, please give details of illness or circumstance of hospitalization?

If your child is restricted from any activities, please explain why:

If your child regularly takes any medication(s), please list the medication, dosage, frequency, and reason below?

| NAME(S) OF MEDICINE(S) | DOSAGE (How much?) | FREQUENCY (How often?) | REASON (Why?) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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**Does your child have any other serious medical conditions?** _____
(Ex. Hypoglycemia, sexually transmitted disease, pregnancy, gastrointestinal disease, chronic fatigue syndrome, etc. )

**IMPORTANT:** Please notify camp if this child is exposed to a communicable disease during the three weeks prior to camp attendance, i.e. strep throat, conjunctivitis (pink eye), chickenpox, etc. Also, if there is new health information concerning your camper after you send in this form, please call (724-238-2400) with those details.

## MEDICATIONS WHILE AT CAMP

Please be sure you listed in the spaces provided all medications your child will bring to camp. Medicine must be in the pharmacy labeled bottle with the correct camper's name. If child is Diabetic, he/she must bring enough insulin for the camp session. A written doctor's prescription must be with the insulin. The child must be able to take blood sugar counts and give insulin on his/her own. DO NOT SEND MEDICINE IN ZIP LOCK BAGS! DO NOT SEND MEDICINE FOR OTHER PERSONS! PLEASE SEND ENOUGH FOR THE ENTIRE CAMP SESSION (1 week)!

In addition to general first aid treatment, camp nurses will also dispense these over-the-counter medicines (often generic) as needed: Acetaminophen (Tylenol), Anti-diarrhea Treatment, Ibuprofen (Advil/Motrin), Constipation Treatment (stool softener), Diphenhydramine (Benadryl), Cough/Throat Lozenges, Stomach meds (Pepto Bismol/Tums/Mylanta), Cough Medicine (Robitussin CF), Chloraseptic Throat Spray, Cold Medicine (Dimetapp/Tylenol Cold), and Loratidine (Claritin).

**PARENT/GUARDIAN AUTHORIZATION:** This application and health history is correct to my knowledge, and I understand the Director reserves the right to dismiss any camper (at the camper's own expense) whose influence and conduct becomes in any way detrimental to the best interests of the other members of camp. The camper listed has permission to engage in all prescribed camp activities except as noted by the examining physician and me. I hereby give my permission to the physician selected by the Camp Director to order x-rays, routine tests, and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, order injection and/or anesthesia and/or surgery for my child as named above. I also give permission for the camp nurse to administer medication to my child as needed. I understand that my child must have adequate medical insurance coverage to attend camp. I expressly covenant and agree not to sue Summer's Best Two Weeks, their agents, officers, directors, board members, or employees for any injuries or damage of any kind that may occur as a result of this camping experience. I realize that Summer's Best Two Weeks reserves the right to use pictures and/or video taken at camp for future promotional purposes.

**Applicant Signature:** _____ **Date:**_____

Please Print name: _____

**Parent/Guardian Signature:**_____ **Date:**_____
(if Applicant is under 18)