



INDIVIDUAL APPLICATION



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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!**

<input type="radio"/> Camper	Are you a...	<input type="radio"/> Kaleo	Have you attended SB2W camp(s) have before? YES <input type="checkbox"/> NO <input type="checkbox"/>	Are you already on a camp team? YES <input type="checkbox"/> NO <input type="checkbox"/>	ROMAN <input type="checkbox"/>
			If so, which? CITIKIDZ <input type="checkbox"/> LG <input type="checkbox"/> QUE <input type="checkbox"/> DAY CAMP <input type="checkbox"/>		GALATIAN <input type="checkbox"/>

Name: Session#: Application Year: **2018**
First Middle Last

Home Address: Home Phone:
Street Apt # Age

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

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

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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? Approximate Date of Ailment

	YES	NO	Approximate Date of Ailment
Chicken Pox.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Measles.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Mumps.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Pregnancy.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Sickle Cell Anemia.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Whooping Cough.....	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

ALLERGIES

Hay Fever/Seasonal	<input type="radio"/> Yes <input type="radio"/> No	Food	<input type="radio"/> Yes <input type="radio"/> No
Insect Bites/Stings	<input type="radio"/> Yes <input type="radio"/> No	Meds	<input type="radio"/> Yes <input type="radio"/> No
Wildlife (poison ivy, poison oak)	<input type="radio"/> Yes <input type="radio"/> No	*Epipen must be provided, if necessary.	

Please specify other allergies or allergies to medication:

Please specify food allergies:

HEALTH CONCERNS

- | | |
|--|--|
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Glasses/Contact lenses |
| <input type="radio"/> Asthma (require inhaler) | <input type="radio"/> Headaches |
| <input type="radio"/> Athlete's Foot | <input type="radio"/> Heart Disease/Concerns |
| <input type="radio"/> Bedwetting | <input type="radio"/> Hemophilia |
| <input type="radio"/> Constipation | <input type="radio"/> Kidney Concerns |
| <input type="radio"/> Corrective Lenses | <input type="radio"/> Nose Bleeds |
| <input type="radio"/> Dental Appliances | <input type="radio"/> Seizures or Convulsions |
| <input type="radio"/> Diabetes | <input type="radio"/> Sickle Cell (trait only) |
| <input type="radio"/> Ear Infections/Concerns | <input type="radio"/> Sleepwalking |
| <input type="radio"/> Fainting | <input type="radio"/> Upset Stomach |
| <input type="radio"/> Frequent Colds | <input type="radio"/> Other |
| <input type="radio"/> Frequent Sore Throats | 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: _____ Date of last
 Medicaid Number: _____ State Issued In: _____ Exp Date: _____ 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?)
_____	_____	_____	_____
_____	_____	_____	_____

*****CONFIDENTIAL*****

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)