APPLICANT

421 WEAVER MILL ROAD, RECTOR, PA 15677 ▪ **PHONE:** 724-238-2400 ▪ **FAX:** 724-238-4400
EMAIL: CITIKIDZ@SB2W.ORG ▪ **TWITTER:** @CITIKIDZCAMP ▪ **FACEBOOK:** SB2DUB!CITIKIDZ

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? If so, which? **CITIKIDZ** ☐ **LG** ☐ **QUE** ☐ **DAY CAMP** ☐

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

GROUP LEADER: **GROUP NAME:**

SESSION | YEAR | FIRST NAME | LAST NAME | SEX | BIRTHDATE | ETHNICITY

CELL PHONE NUMBER | LINE 1 ADDRESS | APARTMENT NUMBER

CITY | STATE | ZIPCODE

GRADE | GPA | GRAD YR | FAVORITE SPORT

SCHOOL

EMAIL ADDRESS

⚠ EMERGENCY CONTACT INFORMATION

CONTACT(S) | RELATIONSHIP | PHONE

INSURANCE COMPANY | POLICY HOLDER NAME

POLICY NO. | POLICY HOLDER BIRTH

RELATIONSHIP TO CAMPER

*Your camper(s) must have adequate medical coverage to attend camp.

*****CONFIDENTIAL*****

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

HISTORY

		DATE
CHICKENPOX	○ Yes ○ No	
COVID-19	○ Yes ○ No	
MEASLES	○ Yes ○ No	
MUMPS	○ Yes ○ No	
PREGNANCY	○ Yes ○ No	
SEIZURES	○ Yes ○ No	
SICKLE CELL ANEMIA	○ Yes ○ No	
WHOOPING COUGH	○ Yes ○ No	

MAJOR INJURIES/SURGICAL HISTORY (PLEASE EXPLAIN):

HOSPITALIZATIONS (PLEASE EXPLAIN BELOW):

CONDITIONS (PLEASE MARK ALL THAT APPLY)

- ☐ Asthma (require inhaler)
- ☐ Athlete's Foot
- ☐ Bedwetting
- ☐ Constipation
- ☐ Dental Appliances
- ☐ Diabetes
- ☐ Ear Infections/Concerns
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Frequent Sore Throats
- ☐ Glasses/Contact lenses
- ☐ Headaches
- ☐ Heart Disease/Concerns
- ☐ Hemophilia
- ☐ Kidney Concerns
- ☐ Nose Bleeds
- ☐ Psychiatric Disorders
  - ☐ ADD/ADHD
  - ☐ Anxiety
  - ☐ Bipolar
  - ☐ Depression
  - ☐ Eating Disorders
  - ☐ Schizophrenia
  - ☐ Self-Injury Behavior
- ☐ Sleepwalking
- ☐ Upset Stomach

Please explain any of the marked items in the space provided:

Please list any activity restrictions:

Other medical comments, i.e. any past or current conditions that may be helpful to a physician if treatment is needed:

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☐ Check this box if you have received the COV-19 **vaccine**. ☐ Check this box if you have received the COV-19 **booster**.

HAS THE CAMPER EVER HAD ALLERGIES OR AN ALLERGIC REACTION TO:

ALLERGY QUESTIONNAIRE:			SEVERITY LEVEL	
◯ Yes	◯ No	Hay Fever/Seasonal	How severe, on a 1-5 scale?	
◯ Yes	◯ No	Insect Bites/Stings	How severe, on a 1-5 scale?	
◯ Yes	◯ No	Wildlife	How severe, on a 1-5 scale?	
◯ Yes	◯ No	Medications	How severe, on a 1-5 scale?	
◯ Yes	◯ No	Food	How severe, on a 1-5 scale?	

SEVERITY LEVEL SCALE:
1 = Not diagnosed, yet mild symptoms
2 = Diagnosed, mild symptoms
3 = Diagnosed, moderate symptoms
4 = Diagnosed, severe symptoms, carries an *epipen
5 = Diagnosed, highly allergic, multiple emergency medical situations

***Epipen must be provided, if necessary.**

Please specify *medication, food* or other allergies:

Please specify any *dietary needs*:

☐ Dairy Free ☐ No Beef
☐ Gluten Free ☐ Vegan
☐ Pollotarian ☐ Vegetarian
☐ No Pork

MEDICATIONS

Check here if your child regularly takes medication? ☐ If so, please list the medication, dosage, frequency, and reason below?

☐ Check this box if you or your child have more medications than the available space on the form allows to be identified.

Medication: Reason:

Dosage:

Frequency:

FAMILY

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

FIRST NAME	LAST NAME	TEAM

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, COVID-19, 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)