

Sample 1

Point 11

****Form must be completed entirely. Please print legibly.

Account Number: _____

Please circle the correct session the camper will attend:

- Session 1: May 31-June 5 Session 4: June 21-26 Session 7: July 12-17 Session 10: August 2-7
- Session 2: June 7-12 Session 5: June 28-July 3 Session 8: July 19-24 Session 11: August 9-14
- Session 3: June 14-19 Session 6: July 5-10 Session 9: July 26-31

Camper Name: _____ Gender: (circle one) M F
First MI Last

Birth Date: _____ Age at Kamp _____ School Grade (Going into) _____
Month/Day/Year

Parent (s) or Guardian (s) Name (s): _____

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Home Address: _____
Street Apt. #

City: _____ State: _____ Zip Code: _____

Ethnic Background: African American Caucasian Latino Other _____

Are both parents living? Yes No Camper lives with: Both Parents Father Mother Other _____

Group Leader Name: _____ Group Name: _____
(Leader of entire group)

In an emergency, please notify:

Name: _____ Relationship: _____ Phone: (_____) _____
 Name: _____ Relationship: _____ Phone: (_____) _____

List All Allergies (medications, foods and others): _____

List current medications (if any changes are made prior to camp please send a Dr's statement):

Drug Name	Dosage	Choose only one column		Special Instructions Attach additional page if- needed
		Must be Given at:	Only Given at camper's Request:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes:				

For Registration Dept. Use only:

Late App: _____ Replacement App: _____

Date Received _____

WL App: _____ Date Removed from WL: _____

Medical History:

Sample 2

Due to the nature of Kids Across America Camps, the following campers are ineligible to attend: those who are pregnant, have Sickle Cell Disease or Hemophilia. We will handle other questionable campers on a case by case basis. Failure to explain any illness indicated below may affect your child's eligibility to attend KAA.

Does your child have any of the following?

Heart Disease or Problems (If so please name the condition) _____ Yes No

Diabetes—Date of Diagnosis _____ (If yes, you must sign diabetic policy) _____ Yes No

Convulsions or Seizures (give date of last seizure and type) _____ Yes No

Any diagnosis resulting in developmental delays: (Please attach an explanation.) _____ Yes No

Active Blood Disorder (HIV, Cancer; Please attach an explanation.) _____ Yes No

Asthma (Give date of diagnosis and last ER visit or hospitalization) _____ Yes No

Incontinence (Chronic bed wetter) If using medication please list on the front. _____ Yes No

Injury or illness requiring active use of a shunt (If so please attach an explanation.) _____ Yes No

Please list any surgical procedures performed within 6 months of your child's attendance to kamp which may hinder his/her performance: _____

If you answered YES to any of the above, please list specific details. Also explain any other illnesses, surgeries, or injuries requiring an ER visit or hospitalization. Include date of illness/injury and any treatment required: _____

Year of last tetanus shot? _____ Name/phone of primary physician? _____

MEDICATIONS WHILE AT CAMP

Please make sure you have listed all medications that your child will bring to camp. All medications must be in the pharmacy labeled bottle with the correct Camper's name on it. Inhalers should be in a pharmacy labeled box. Sample medications should be accompanied by a written order from the physician. If a 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 UNLABELED MEDICINE IN ZIP LOCK BAGS! DO NOT SEND MEDICINE FOR OTHER PERSONS! PLEASE SEND ENOUGH FOR THE ENTIRE KAMP SESSION!

PARENT/GUARDIAN AUTHORIZATION: This health history is correct to my knowledge, and the camper listed has permission to engage in all prescribed camp activities. 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. In the event that my child needs treatment at an outside medical facility, I give permission to release medical records to KAA for any further treatment and observation at camp.

I understand the Director reserves the right to dismiss any camper (at the group's own expense) whose influence and conduct becomes in any way detrimental to the best interests of the other members of the camp. I expressly covenant and agree not to sue Kids Across America Camps, their affiliates, 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.

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

Parent Signature _____

Date _____