

## CAMP ABLE AT CORONADO- CAMPER APPLICATION

Agency Name: \_\_\_\_\_

Contact Person's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dates Attending Camp: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Email \_\_\_\_\_

In case of emergency, contact:

1. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

### HEALTH HISTORY

Conditions and limitations, which may effect the camper's participation, must be reported on this application.

1. Has the camper had a health examination within 24 months prior to camp? Yes\_\_\_ No\_\_\_

2. Has the camper had the required immunizations? Yes\_\_\_ No\_\_\_

Polio: Date \_\_\_\_\_ DPT: Date \_\_\_\_\_ MMR: Date \_\_\_\_\_

3. Does the camper have allergies: Yes\_\_\_ No\_\_\_ Describe: \_\_\_\_\_

4. Does the camper have a disability or health problem? Yes\_\_\_ No\_\_\_

If "yes", what is the diagnosis? \_\_\_\_\_

5. Does the camper have seizures? Yes\_\_\_ No\_\_\_

If "yes", describe: \_\_\_\_\_

6. Does the camper take medication? Yes\_\_\_ No\_\_\_

If "yes", what medication? \_\_\_\_\_

7. Are there any other conditions or limitations which may effect the camper's participation at Camp Able (wheelchair, walker, braces, etc.)? Yes\_\_\_ No\_\_\_

If "yes", describe: \_\_\_\_\_

8. Does the camper need special attention for feeding/toileting/dressing? Yes\_\_\_ No\_\_\_

If "yes", describe: \_\_\_\_\_

9. Will the camper require the services of the Camp Able Nurse for medical treatment or for administering medication? Yes\_\_\_ No\_\_\_

**IF "YES", A SEPARATE MEDICAL FORM MUST BE SUBMITTED.**

10. Summarize past medical treatments: \_\_\_\_\_

11. Primary Health Care Provider/Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### PARENTAL/GUARDIAN PERMISSION

I give my permission for the above named camper to participate in the Camp Able Program. I authorize emergency medical treatment at the hospital designated by the emergency medical personnel. I authorize emergency first aid by the Camp Able registered Nurse or the Camp Able Certified Staff. Yes\_\_\_ No\_\_\_

SIGNATURE: \_\_\_\_\_ NAME (PRINT): \_\_\_\_\_

RELATION: \_\_\_\_\_ E-MAIL \_\_\_\_\_

I consent that Camp Able may use photographs or videos of my son/daughter, taken while at Camp Able, on their social media tools which includes but is not limited to their website, Facebook, Instagram, or Twitter accounts. I understand that these images and/or videos will not be used for any other commercial purposes.

Yes\_\_\_ No\_\_\_ SIGNATURE: \_\_\_\_\_ NAME (PRINT): \_\_\_\_\_

Relation: \_\_\_\_\_