CAMP APPLICATION FORM

Course/Session Dates _____
Scholarship (amounts requested) _____
(must be approved by O.E. Director)
Fees Paid (amount) _____
Camper Billet #

Boys & Girls Clubs of Metro Atlanta

Camp Kiwanis
2613 Old Wildcat Bridge Road
Danielsville, GA 30633
1-706-795-2098
1-706-795-0970

Name_____ Club _____

Address_____ Membership # _____

City _____ Social Security # _____

State _____ zip _____ School _____

Age _____ Birth date _____ Grade Completed _____

Is youth on USDA or reduced lunch program? Yes _____ No _____

Parent(s)/Guardian Name(s) _____

Phone: (work) _____ (home) _____

Dates attending camp:

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Phone: (work) _____ (home) _____

Address

Permission & Medical Release:

As parent/guardian of the above named youth, I give permission for him/her to attend this Camp Kiwanis program. In the event I can not be reached, I give permission to the physician selected by Camp Kiwanis staff to provide emergency medical treatment/hospitalization for the above named individual.

****PARENT SIGNATURE*** Date

CAMPER'S ACCEPTANCE OF RESPONSIBILITY

Because I will be participating in Outdoor and Waterfront activities, I understand the importance of following counselor/staff instructions regarding safety, activity procedures, and group living rules.
I agree to obey all such instructions and follow all guidelines and procedures.

Camper Signature Date

Boys & Girls Clubs welcome youth from all ethnic and religious groups. The following information is for statistical use only and is optional. Check all that apply: __ Afro American; __Native American; __ Indo/Asian; __ Hispanic; ___ Anglo; ___ Other

HEALTH HISTORY

(To be filled out by parent/guardian)

Name _____

Doctor's Name _____ Phone _____

Insurance Company _____ Policy Number _____

Is camper on any medication? Yes _____ No _____

If yes, please specify _____

_____

Is camper allergic to any drugs, etc? Yes _____ No _____

If yes, please specify _____

_____

Is camper subject to/had the following? **Please check, giving approximate/last dates:**

	√	DATES		√	DATES
* Frequent Sore Throat	__	____	* Ivy Poisoning	__	____
* Ear Infection	__	____	* Insect Stings	__	____
* Convulsions	__	____	* Diabetes	__	____
* Fainting Spells	__	____	* Rheumatic Fever	__	____
* Constipation	__	____	* Asthma	__	____
* Nose Bleeds	__	____	* Chicken Pox	__	____
* Sleepwalking	__	____	* Measles	__	____
* Hay Fever	__	____	* Mumps	__	____

Recently exposed to contagious disease? Yes _____ No _____
If yes, what disease and
date:_____
Chronic or recurring illness? _____ Give details: _____
Serious operations or injuries? (give dates): _____
Any activities to be encouraged: _____
Any activities to be restricted: _____

IMMUNIZATION HISTORY (give dates):

DPT Series:	_____	Measles Vaccine (live):	_____
DPT Booster:	_____	German Measles (Rubella):	_____
Polio OPV (Sabin):	_____	Mumps Vaccine:	_____
Polio Booster:	_____	Tuberculin Test:	_____
Tetanus Booster:	_____	Typhoid Vaccine:	_____

CAMP HEALTH RECORD (TO BE FILLED OUT BY CAMP STAFF)

Medical Record Complete Yes ____ No ____

Allergies: Yes____ No ____
If yes, what? ________________________________

____

Is camper on any medication? Yes_ No____

Did camper bring it with him/her? Yes___ No ___

Medication brought by camper:(name/dose/time)
____
____
____

Pertinent information noted from medical records:
____
____
____

Does camper wear glasses? Yes______ No______

Did camper bring eye glass holder? Yes______ No______

Did camper bring them to camp? Yes______ No______

Health Screening Findings:

Weight ___________ Any unusual Scars _____________

Rash/Sores _________ Athletes Foot_________________

Other ____

Follow-up Needed: _________________________________

Nurse's Comments: _________________________________
____
____
____

Signature ____

Date ____

MEDICAL LOG

MEDICAL EXAMINATION: Camper name: _____

This examination must be performed within 12 months of arrival at Camp Kiwanis. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

CODE: S-Satisfactory; O-Not Examined; X-Not Satisfactory; Explain

Height _____ Weight _____ B.P._____
Urinalysis _____
Ears _____
Nose _____
Throat _____
Teeth _____
Heart _____
Abdomen _____
Hernia _____

HGB/Test _____
Eyes _____
Glasses _____
Extremities _____
Posture (spine)_____
Skin _____
Allergy: Please specify
_____

Recommendations and restrictions while in camp:_____

Under special diet: Yes ____ No ____ Explain: _____

Special Medicine:_____ **Will it be needed at camp?** _____

Swimming, diving, or other strenuous activity: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as note above.

_____ _____
Authorized Personnel Date

In the event of an accident (at camp), fill out in detail (FOR CAMP USE ONLY)

Time of Accident _____

Type of injury (explain in detail: Where, How, etc.)

Kind of treatment given (in detail when first notified)

Treatment administered by: _____ Position _____

Witness to Accident (dive name, address, phone, and club number):

(1)	(2)	(3)

Was parent notified? _____ Was Club notified? _____
If taken to hospital for treatment, where?_____ when? _____

ATTACH COPY OF HOSPITAL OR DOCTOR REPORT.