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

CAMP APPLICATION FORM

(Please Print)

Name___________________________________Please check the Branch of Service your love one is in:

□ Army; □ Coast Guard; □ Navy; □ Marines; □ Air Force; □ U.S. Public Health Service;

□ National Oceanic Atmospheric Administration; □ National Guard & Reserves

Address____Club_____________

City _____________ State ________ zip ________ School _______________________________

Age _____ Birth date ________________Male_______Female ______ Grade Completed _________

Is youth on USDA or reduced lunch program? Yes ______ No ________

Parent(s)/Guardian Name(s) ____

Phone: (work) ________________ (home) __________________(cell)_______ ________________

Dates attending camp: July 19-25, 2009 email ____

IN CASE OF EMERGENCY, if parent (s)/ guardian can not be reached, CONTACT:

Name ____ Relationship ___________________

Phone: (work) __________________ (home) _________________ (cell) ________________

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)

Camper Name ____

Doctor's Name ______________________________ Phone ________________

Insurance Company _________________________ Policy Number ______________

Is camper on any medication? Yes ______ No _____ If yes, please specify:

Medication:________________________Dose: _____________________Time (s) _________________

(All medications must be in original bottle!)

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: ____

Note: If camper wears eyeglasses, he/she must bring eyeglass holder & strap to camp.

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 eye glasses? Yes ____ No ___
Did camper bring them to camp? Yes ____ No __
Did camper bring eye glass strap, holder?
Yes ___ No ___

Health Screening Findings:

Weight _______Any unusual scars ___________

Rash/Sores _______ Athletes Foot ____________

Other ___________________________________

Follow-up
Needed:_________________________________
____
____
____

Nurse's Comments:
____
____
____
____

Signature _________________________________

Date ____________________________________

- -

Medical Log (information also logged in the camp health log book)

DATE	PROBLEM	TREATMENT	SIGNATURE

MEDICAL EXAMINATION **Camper name:____**

This examination must be performed within 24 months of arrival at Camp Kiwanis. Examination for some other purpose within this period is acceptable. Please attach their physical form. 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 <u>(FOR CAMP USE ONLY)</u>

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 (give name, address, hone, and club number):

(1)	(2)	(3)	(4)

Was parent notified? ______________________ Was Club notified? _____________
If taken to hospital for treatment, where? ____________________ When? _______________

ATTACH COPY OF HOSPITAL OR DOCTOR REPORT.