CAMPER APPLICATION

APPLICATION DEADLINE:
MAY 1 for ALL pages
(including physician form)

Contact: Bob Degen
918-855-0817
hopescrossingcamp@gmail.com
P.O. Box 4423, Tulsa, OK 74159

CAMPER's FULL NAME _____ **DATE RECEIVED** _____

Parent/Guardian Information

Name _____ Name _____

Address _____ Address _____

City _____ State ____ Zip Code _____ City _____ State ____ Zip Code _____

Phone Home _____ Phone Home _____

Phone Cell _____ Phone Cell _____

Email _____ Email _____

Camper lives with (circle one) Both Parents Mother Father Guardian

Camper may be released to _____ Cell _____

Emergency Contact Information (Someone other than parent—who is available during camp hours)

Emergency Contact Name _____

Emergency Contact Phone (H) _____ Cell _____

Relationship to camper _____

Camper Information

Name _____ **Nickname** _____

Gender (circle): Male or Female

Camper Date of Birth _____ Age _____ Weight _____ Height _____

School _____ Grade Completed _____

Special Interests or Hobbies: please list (e.g. music, painting, archery, soccer, swim lessons, basketball, games…)

_____

Camper T-Shirt - Please circle one T-shirt size for your camper

Child Small (6-8) Medium (10-12) Large (14-16) **Adult** Small Medium Large Extra Large

How did you hear about us? _____

Photo Release: (Your signature gives permission for Hope's Crossing Camp to use photographs of your child.)
I hereby consent that the photographs and/or videotapes in which my child appears and/or audio recordings made of his/her voice may be used by Hope's Crossing Camp in whatever way needed, including television; consent that any such photograph, films and recordings shall be the property of Hope's Crossing Camp, and they shall have the right to duplicate and reproduce and make other such use of said photographs as needed without any claim on my part.

Parent/Guardian signature _____ **Date** _____

HEALTH INFORMATION and RELEASE FORM

Contact Bob Degen: hopescrossingcamp@gmail.com
Phone: 918-855-0817

Date received by HCC _____

CAMPER's FULL NAME _____

Primary Diagnosis:

_____Amputation Cause: _____ Level: _____
_____Cancer Type: _____
_____Cerebral Palsy
_____Head Injury Cause: _____
_____Muscular Dystrophy
_____Stroke
_____Spinal Cord Injury Cause: _____ Complete_____ Incomplete ___
_____Visual Impairment
_____OTHER (explain disability AND cause) _____

Is disability _____ **Present at birth or**_____**Acquired/diagnosed on this date**_____

Camper uses: power wheelchair _____manual wheelchair____crutches _____ prosthesis ____ walker _____

Other (please describe) _____

List surgeries and dates:_____

NOTE: Camper must have independent skills of daily living such as feeding and toileting (no diapers allowed).

BRING ALL MEDICATIONS ON FIRST DAY OF CAMP in original container, bagged and labeled with name.

Allergies: _____

Special Dietary Restrictions: _____

Describe behavioral and/or emotional issues:_____

_____

ARE THERE ANY OTHER HEATLH PROBLEMS—please describe : _____

_____

Is the camper's **immunization record** in compliance with OK state school requirements for school attendance? Yes No

Hospital Preference _____Date of last Tetanus Shot _____

Health Insurance Company _____ID# _____

Physician's Name _____**Phone** _____

Dentist's Name _____**Dentist Phone** _____

_____**Authorization for Medication:** I give permission for administration of the following medications if deemed necessary by certified first-aid personnel or nurse. Doses will be administered according to directions on label unless directed by physician.

Please check the medication your child <u>is allowed</u> if needed: __Tylenol __Chewable Antacid __Pepto Bismal __Benadryl

_____**Authorization for Treatment:** I give permission to the medical personnel selected by Hope's Crossing Camp to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange any necessary related transportation for my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. The completed forms may be photocopied.

Parent/Guardian signature _____ **Date** _____