Summer Camp Registration

Please print using black or blue ink. Please mail, fax, or e-mail form to Hope's Haven by May 11, 2012 (for June camp) and July 20, 2012 (for August camp).

P.O. Box 251 | Shamokin Dam, PA 17876
Phone: 570-850-9443 | Fax: 877-335-6214
info@hopeshavencamp.org

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Gender: ______ Age: ______ Birth Date: ______________

Parents or Guardians: ______________________________

Phone: (_____) ________________ Work Phone: (_____) ______________

Parent's Email: ______________________________ Parent's Mobile Phone: (_____) ______________

Caseworker & Address: ______________________________

Worker Email: ______________________________ Worker Phone: (_____) ______________

Originating County: ______________ Group Home or Agency Name: ______________________________

Alternative Emergency Contact: ______________________________ Phone: (_____) ______________

DATE OF CAMP: ❑ **June 11-15 (grades 7-9)** ❑ **June 18-22 (grades 4-6)** ❑ **Aug. 17-19 (grades 10-12, returning campers only)**

Grade child will be entering: ❑ 7th ❑ 8th ❑ 9th ❑ 4th ❑ 5th ❑ 6th ❑ 10th ❑ 11th ❑ 12th

TRANSPORTATION: ❑ **Agency will provide camper transportation** ❑ **Hope's Haven transportation** ❑ **Parent/Guardian**

Hope's Haven will provide transportation from Harrisburg, Lancaster, York, and Shamokin Dam.
More pick-up/drop-off locations may be added if there are concentrations of registered campers from other areas.

COST: The **only** cost is a **$5.00** registration fee. (Send with this form.) *Camp is lovingly sponsored by our donors who want to help.*

CHILD'S T-SHIRT SIZE: __________ ❑ Youth size ❑ Adult size

MEDICAL INSURANCE: Provider: ______________________________ Policy No: ______________

Provider Phone (_____) ______________ ID No: ______________________________

HEALTH HISTORY: *Indicate date of illness, severity, complications and any residual impairments.*

		MUSCULOSKELETAL:	ALLERGIES:
Respiratory Problems ________	Hypoglycemia ____________	Foot ______________	Hay Fever ____________
Heart or Circulation ________	Dizzy ______________	Back ______________	Poison Oak ____________
Pulmonary Edema ________	Seizure Disorders ________	Other ______________	Insect Bites ____________
Anaphylactic Shock ________	Balance Problems ________		Drug Allergy ____________
Diabetes ______________	Fainting ______________		

Details from above: ______________________________

Operations or Recurring Illness: ______________________________

Any specific activities to be encouraged? ______________________ Restricted? ______________________

IMMUNIZATION HISTORY: Please fill in dates of basic immunizations and most recent booster.

DTP Series ______________	Booster ______________	Tetanus Booster ______________
Polio OPV (Sabin) ______________		Typhoid ______________
Measles Vaccine (live) ______________		Tuberculin Test ______________
German Measles (Rubella) ______________		Mumps Vaccine Live ______________
Small Pox ______________		Other ______________

MEDICATIONS: Is your child taking any medications? ______________ If yes then fill in the following:

Name of Medication	Dosage	Times

Doctors Name: ______________________________ Phone: (_____) ______________

Please add any other comments related to Health and Medications on the back of this sheet.

If you do not want the child to receive over the counter medications or remedies for minor illness or injuries please check this box. ❑

MEDICAL RELEASE: *This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted by me. The undersigned do hereby authorize the directors of HOPE'S HAVEN or such substitute as they may designate as agent for the undersigned to consent to any X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is in route to and from or involved or participating in any camp activity, unless revoked in writing by the undersigned and delivered to the Director.*

Parent or Guardian Signature: ______________________________ Relation: __________ Date: __________

Form must be signed to be a valid registration. A confirmation will be sent within two weeks.