

2021 Summer Camp Registration



Please, print clearly using black or blue ink. This form must be *completely* filled out in order for your child to be registered. Then mail or email form to Hope's Haven by April 30, 2021. If you are completing this application after April 30, please contact us for space availability.

PO Box 86, Williamstown, PA 17098

Phone: 570-850-9443

Email: info@hopeshavencamp.org

Name: _____

Address: _____

City/State/Zip: _____

Gender: _____ Age: _____ Birth Date: _____

Child is living with: (Check one) Foster Parent Group Home Relative: _____

Adoptive Parent

Biological Parent

Hope's Haven is a specialized camp for children who have been in foster care.

Has your child ever been in foster care? _____

Parents/Guardians (P/G) with whom child is living: _____

P/G Home Phone: (____) _____

P/G Work Phone: (____) _____

P/G Mobile Phone: (____) _____

P/G Email: _____

Caseworker: _____ Email: _____ Phone: (____) _____

Originating County: _____ Agency Name or Group Home: _____

Alternative Emergency Contact: _____ Phone: (____) _____

DATE OF CAMP (all camps will be held at Camp Swatara, Bethel, PA):

June 9-12 for Grades 4-7 June 16 to 19 for grades 8-12

GRADE: Grade child will be entering this fall _____

Returning Camper? yes no

CHILD'S T-SHIRT SIZE: _____

Youth size Adult size

COST: Registration fees have been waived. *Camp is lovingly sponsored by our donors.*

TRANSPORTATION: (If possible, please transport your children to camp this year. If you are unable to bring them to camp, we will plan accordingly for transportation.)

Agency will provide transportation Hope's Haven transportation* Parent/Guardian

*Hope's Haven will provide transportation from Harrisburg, Lancaster, York, Shamokin Dam and surrounding areas. We will contact you closer to camp to confirm transportation.

SIBLINGS: Will this child be attending camp with a sibling (biological, foster, or adoptive): **Yes, No, or Unsure?**

Name of sibling: _____ If yes, do you recommend that they be in the same group for activities?

Please explain. _____

MEDICAL INSURANCE: Provider: _____

Policy No: _____

Provider Phone: _____

ID No: _____

IMMUNIZATION HISTORY: *Please, fill in the dates of basic immunizations and most recent booster, or attach immunization record.*

_____ Tdap Series

_____ Tdap Booster

_____ Tetanus/Booster

_____ Polio OPV (Sabin)

_____ Chicken Pox

_____ Tuberculin (TB) Test

_____ Measles, Mumps, Rubella

_____ TB Test

_____ Hep A &/or B

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

Respiratory Problems _____	Dizziness _____	MUSCULOSKELETAL:	
Heart or Circulation _____	Seizure Disorders _____	Foot _____	Poison Ivy _____
Pulmonary Edema _____	Balance Problems _____	Back _____	Insect Bites _____
Anaphylactic Shock _____	Fainting _____	Other _____	Drug Allergy _____
Diabetes _____		ALLERGIES:	Dye, Wheat, or other Food Allergy _____
Hypoglycemia _____		Hay Fever _____	_____

Operations or recurring illness: _____

Special eating concerns/diet: _____

Any specific activities to be encouraged? _____ Restricted? _____

MEDICATIONS: Will your child be taking any medications at camp? _____ If yes, then please fill in the following:

(Note: All medications must be provided in their ORIGINAL containers and must match the first and last name of the child listed on the application. If more space is needed, please attach additional paper.)

Name of Medication	Dosage	Times
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor's Name: _____ Phone: (_____) _____

Camper's Emotional/Behavior History:

- | | | | |
|----------------------------------------------|----------------------------------------|---------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Aggressiveness | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Biting | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Running Away | <input type="checkbox"/> Sexual Acting Out |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Other _____ |

For any of these behaviors, what modifications work well for this child? _____

Please add any other comments related to HEALTH, MEDICATIONS, OR EMOTIONAL BEHAVIOR below.

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.*

CONFIDENTIALITY STATEMENT: *We respect your right to privacy. All information regarding camper applicants will be held confidential within pertinent camp staff on a need-to-know basis for the purposes of determining admission and providing the best camper experience possible to your child. However, confidentiality may be breached in the event of an emergency or if a safety concern arises for your child or others that requires attention. All camp staff are mandated reporters of child abuse according to Pennsylvania law.*

Parent/Guardian Signature: _____ Relation: _____ Date: _____

Registration is not complete unless form is signed. After sending in the registration, a confirmation will be sent to you by May 1.

PLEASE COMPLETE THIS FORM.

Camp Swatara
Activity Release & Health Statement Form
Challenge Course Participant

This activity requires participation in field exercises which are, by their nature, physically demanding. Therefore, all participants must be free of medical or physical conditions which might create undue risk to themselves or others who depend upon them. Medical attention is available only through the local emergency response network. Physical strength is not necessary for the majority of course elements, but being in good condition will increase your enjoyment of the Challenge Course. If there is any doubt about your ability to safely participate in the Challenge Course activities, you should have a physical examination.

1. What physical disabilities or condition do you have which might limit your participation in this activity?

2. What else might affect your participation?

3. What medications are you taking?

4. List the name, address, and phone number of person(s) to contact in an emergency.

Please Note: The Challenge Course participant has a “challenge by choice” option before beginning course and after the first obstacle (rope ladder or climbing wall) on the high ropes course. No refunds can be given if a participant chooses to pass on that challenge.

“I have read and understand the nature of the physical demands of this activity. I have noted above any medical or physical conditions I have which might affect my activity. I, therefore, release any and all rights or claims for damage against Camp Swatara or affiliated organizations and all individuals assisting in instructing and conducting these activities for any and all injuries loss or damages suffered by me at, or in any way connected with these injuries.”

Name (print): _____ Date: _____

Signature: _____

Activity Name/Date: Hope's Haven Camp - June 9 to 12 and June 16 to 19

Parent/Guardian Signature: _____