

Charles Campbell Childrens Camp **CAMPER APPLICATION**
Camp dates July 13-18, 2008

PO Box 23342
Billings, MT 59104
(406) 652-0438
e-mail: campbellcamp@msn.com

Child's Name _____ Nickname _____ Age _____
Address _____ Birthdate _____ Sex _____
City _____ State _____ Zip code _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail address _____

Has your child attended the Charles Campbell Camp before? Yes _____ No _____ Year _____

Disability/Condition: _____

Communication Ability: _____

Physical limitations: _____

ambulates freely ___ ambulates w/ walker ___ ambulates with crutches ___ wheelchair bound ___

*Please send wheelchair with your child if he/she uses one for long outings. **No Electric wheelchairs!**

Special Equipment Needs (will bring to camp): Wheelchair ___ Braces ___ Feeding Equip. ___

Crutches ___ Hearing aid ___ Toileting devices ___ Walker ___ Diapers ___

Other _____

Behavioral Issues (tantrums, biting, self abuse) _____

Ways you handle these situations: _____

Please be honest so that we are aware of problems and can handle them in an effective manner. If we feel your child is detrimental to the other children in camp, we will call and ask that you come and get him/her. Please use separate sheet if necessary to explain or call us and we can talk about it.

Eating:

Special Diet/equipment/needs: _____

Eats independently? ___ Favorite Foods: _____

Dislikes: _____

Other: _____

Dressing: Independently ___ Needs help with _____ Other _____

Bathroom: Independently ___ Needs help with _____

What times taken to the bathroom _____

Special Needs / instructions to assist your child in their camp experience: _____

I hereby affirm that I am the parent/guardian of _____ and consent that photographs, videos, or any other Media reproduction of same taken of him/her may be used by the Camp Director, Staff, and or the Billing's Lions Club to advertise or publicize in any manner.

I give my permission to participate in the camp program sponsored by the Billing's Lions Club and release the Lions Club and the camp staff from any liability resulting from such activity.

Parent/Guardian Signature _____ Date _____

Medical Information

Child's Name _____ Birthdate _____

Allergies to:
(Medications) _____

(Food :) _____

(Other:) _____

Prescription Medications: **PLEASE** be very specific with the dosage and times you give your child each different medication: **Use another piece of paper if you need more room for instructions or medications.** If the camp staff has questions we will call you to ensure proper medication.

Name of Med. _____ Dose _____ Times given _____

Name of Med. _____ Dose _____ Times given _____

Name of Med. _____ Dose _____ Times given _____

Name of Med. _____ Dose _____ Times given _____

Over the counter meds. / Other Non-Prescription (vitamins, Tylenol, cough syrup, etc.)

Med name: _____ Dosage: _____

Med name: _____ Dosage: _____

Med name: _____ Dosage: _____

Other Instructions: _____

Emergency Consent to Treat (name) _____ for Dates _____

I hereby give my permission to any available physician or member of hospital medical staff to perform emergency medical treatment and procedures for (name) _____ as he/she deems necessary, and to continue treatment and procedures until such time as the undersigned shall dismiss or engage another physician. This permission includes admission to the local hospital if the physician deems necessary.

It is also understood that the Charles Campbell Camp, the staff, and the Billing's Lions Club are released from any liability which may be incurred,

Parent/Guardian Signature _____ **Date** _____

Print Name _____

Daytime phone # _____ Evening Phone # _____

Witness Signature _____ **Date** _____

Emergency Contact (if you are unavailable) Name _____

Relationship _____ Phone #'s _____

Please answer the questions below:

Physician preference _____

Hospital Preference _____

Date of last Tetanus Booster _____

Insurance carrier _____ Policy number _____

Medical conditions _____

Comments: _____
