CampOpenAirways
NavicentHealth

CAMP APPLICATION

June 9th, 2018

Instructions: Complete this form in its entirety. Parent or legal guardian signature is required on this application. Email to fox.valerie@navicenthealth.org or complete application and mail to 777 Hemlock Street MSC 23, Macon, GA 31201. Include a photo of your child/children. If you have questions or need assistance contact (478) 633-2965. Registration includes: food, & activities of the camp. The camp is free of charge. Parent or Guardian MUST attend with the child. This camp provides an informational session for parents or guardians.

CHILD CAMPER (*complete one application per child*)

_____ _____ _____

(First Name & Nickname if used) (M.I.) (Last)

GENERAL INFORMATION:

Age: _____ School Grade: _____ Date of Birth: ____ / ____ / _____

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other

What school does your child attend? _____

MEDICAL INFORMATION:

Significant Allergies (*specify*)

☐ Insect Sting: _____

☐ Medicine/Drug: _____

_____

☐ Plant/Pollen: _____

☐ Other: _____

Recent Surgery? _____

Immunizations Current? _____

LIST OF CURRENT MEDICATIONS:

***Medicine:**

_____

_____

_____

Check all that apply, explain:

☐ Asthma: _____

☐ ADD: _____

☐ ADHD: _____

☐ Diabetes: _____

☐ Seizures: _____

☐ Stomach Conditions: _____

☐ Heart Conditions: _____

☐ Other: _____

**Please list all medications taken on a daily basis.*

FOOD & DIET INFORMATION

Significant Allergies (*specify*)

I have the following food allergies: _____

Please specify any diet restrictions: _____

MEDICAL HISTORY

Pediatrician/Family Physician: _____ Phone: _____

ADULT CAMPER 1

_____ _____ _____

(First Name & Nickname if used) (M.I.) (Last)

GENERAL INFORMATION:

Age: _____ Date of Birth: _____ / _____ / _____

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other

Relationship to child attending? _____

MEDICAL INFORMATION:

Significant Allergies (*specify*)

☐ Insect Sting: _____

☐ Medicine/Drug: _____

_____

☐ Plant/Pollen: _____

☐ Other: _____

Recent Surgery? _____

Immunizations Current? _____

LIST OF CURRENT MEDICATIONS:

***Medicine:**

_____

_____

_____

Check all that apply, explain:

☐ Asthma: _____

☐ Diabetes: _____

☐ Seizures: _____

☐ Stomach Conditions: _____

☐ Heart Conditions: _____

☐ Other: _____

**Please list all medications taken on a daily basis.*

FOOD & DIET INFORMATION

Significant Allergies (*specify*)

I have the following food allergies: _____

Please specify any diet restrictions: _____

MEDICAL HISTORY

Family Physician: _____ Phone: _____

ADULT CAMPER 2

_____ _____ _____

(First Name & Nickname if used) (M.I.) (Last)

GENERAL INFORMATION:

Age: _____ Date of Birth: _____ / _____ / _____

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other

Relationship to child attending? _____

MEDICAL INFORMATION:

Significant Allergies (*specify*)

☐ Insect Sting: _____

☐ Medicine/Drug: _____

_____

☐ Plant/Pollen: _____

☐ Other: _____

Recent Surgery? _____

Immunizations Current? _____

LIST OF CURRENT MEDICATIONS:

***Medicine:**

_____

_____

_____

Check all that apply, explain:

☐ Asthma: _____

☐ Diabetes: _____

☐ Seizures: _____

☐ Stomach Conditions: _____

☐ Heart Conditions: _____

☐ Other: _____

**Please list all medications taken on a daily basis.*

FOOD & DIET INFORMATION

Significant Allergies (*specify*)

I have the following food allergies: _____

Please specify any diet restrictions: _____

MEDICAL HISTORY

Family Physician: _____ Phone: _____

ADDRESS:

Street: _____

City: _____

Zip code: _____

PHONE:

Home: (_____) _____

Parent/Guardian Work Number: (_____) _____

Parent/Guardian Cell Number: (_____) _____

Email address for family/parent or guardian: _____

T-SHIRT SIZE:

Youth Sizes: ☐ S (6 – 8) ☐ M (10 – 12) ☐ L (14 – 16)r

EMERGENCY CONTACT INFORMATION:

Please list the name of 2 persons you would like us to contact in case of an emergency.

Contact 1:

_____	_____	_____
Name	Phone Number	Relationship to child

Contact 2:

_____	_____	_____
Name	Phone Number	Relationship to child

INSURANCE INFORMATION:

Insurer Name: _____

Carrier: ☐ Medicare ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ TriCare ☐ HMO

Other Commercial Name: _____

Insurance #: _____