Bo's Camp Adult Application
September 27-29, 2024

INSTRUCTIONS: Complete this form in its entirety. Email to BosCamp@atriumhealth.org or mail to 777 Hemlock Street MSC 38, Macon, GA 31201. If you have questions or need assistance, call 478-633-1503. Registration includes food & activities for the day. Bo's Camp is free of charge to each camper. ONLY COMPLETE APPLICATIONS WILL BE ACCEPTED. One camper per application

Adult Camper Name:

_____ _____ _____
(First Name & Nickname) (M.I.) (Last)

Name of Child/Children and Relationship to Child Attending Camp:

_____

_____

Address:
Street: _____
City: _____
Zip code: _____

Phone Numbers:
Home: (_____) _____
Work Number: (_____) _____
Cell Number: (_____) _____

Email address: _____

T-Shirt Size:
Youth Sizes: ☐S ☐M ☐L Adults Sizes: ☐S ☐M ☐L ☐XL ☐XXL ☐XXXL ☐XXXXL

General Information:
Age: _____ School Grade: _____ Date of Birth: _____/_____/_____
Sex: ☐Male ☐Female Race: ☐White African ☐American ☐Hispanic ☐Other: _____

How did you hear about Bo's Camp? _____

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

	Name	**Phone Number**	**Relationship to child**
Contact #1:	_____	_____	_____
Contact #2:	_____	_____	_____

Insurance Information:
Insurer Name _____
Carrier: ☐Medicare ☐Medicaid ☐Blue Cross/Blue Shield ☐Tricare ☐HMO
☐Other Commercial Name: _____
☐Insurance # _____

Medical History
Pediatrician/Family Physician: _____ Phone: _____

MEDICAL INFORMATION **Significant Allergies (specify)**	LIST OF CURRENT MEDICATIONS ****Medicine:**
☐Insect Sting: _____ _____ ☐Medicine/Drug: _____ _____ _____ ☐Plant/Pollen: _____ _____ ☐Other: _____ _____ Recent surgery or hospitalization? _____ Immunizations Current? ☐YES ☐NO COVID Vaccine ☐YES ☐NO	_____ _____ _____ **Check all that apply, explain:** ☐Asthma: _____ ☐Diabetes: _____ ☐Seizures: _____ ☐Stomach Conditions: _____ ☐Heart Conditions: _____ ☐Other: _____

FOOD AND DIET INFORMATION

Significant Allergies (specify)

I have the following food allergies: _____

Please specify any diet restrictions: _____

Adult Bereavement History

Please include as many details as possible when answering the following questions. This will assist our staff in planning. Feel free to write on the back of this form or attach additional pages if necessary.

1. Who was the person(s) who died (name): _____

2. Age(s) _____

3. Cause of death? _____

4. Were you present at the time of the death? ☐Yes ☐No

5. Where did this person die? ☐Home? ☐Hospital? ☐Other _____

6. When did the death occur? (date) _____

7. Did you attend the funeral/memorial service? ☐Yes ☐No
If yes, explain how you felt at the service:

_____

_____

8. Have you received any professional support to help with the grieving process? ☐Yes ☐No
If yes, is support currently being provided? ☐Yes ☐No
If counseling is no longer in progress how long was the period of support provided?

_____

_____

9. Have there been multiple deaths of loved ones? ☐Yes ☐No
If yes, please describe the nature of death and the relationship to the person that died.

_____

_____

10. Have there been any other changes or stresses in your life? (i.e., divorce, remarriage, relocation, illness, etc.)

_____

_____

11. Any suicide attempts? If yes, please explain:

_____

_____

_____ _____

Print name Signature

_____

Date