Atrium Health Levine Children's

Bo's CAMP

A program by Atrium Health Levine Children's Beverly Knight Olson Children's Hospital

Bo's Camp Adult Application
September 26-28, 2025

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: ______________________________
Email address: ______________________________

Phone Numbers:
Home: (______) ______________________________
Work Number: (______) ______________________________
Cell Number: (______) ______________________________

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	LIST OF CURRENT MEDICATIONS
Significant Allergies (specify) ☐Insect Sting: ____________________ ____________________ ☐Medicine/Drug: ____________________ ____________________ ____________________ ☐Plant/Pollen: ____________________ ____________________ ☐Other: ____________________ ____________________ Recent surgery or hospitalization? ____________________ Immunizations Current? ☐YES ☐NO COVID Vaccine ☐YES ☐NO	****Medicine:** ____________________ ____________________ ____________________ **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