CAMPER APPLICATION 2011

Camp Director with responsibility for Campers
Brooke Bateman,
106 E. 27th St, Merced CA 95340
Tel: (209) 769 4315 email ilybrookeb@yahoo.com

Camper Information and Office:
USPO Box 110, 257 Belle Vue Road Atwater Ca 93301

We are pleased to announce our 2011 CAMP PACIFICA Summer Program for deaf and hard of hearing children. We are celebrating our 33rd year of providing exciting summer camp activities for children throughout California and Nevada. All of our camp sessions are held at Camp Pacifica located in the Sierra Nevada foothills. It is located on Highway 49 between Mariposa and Oakhurst near Awahnee.

Our camp program is open to boys and girls seven (7) to 15 years of age. Our Campers in Leadership Training program is for young adults ages 16 and 17. Campers enjoy an outdoor adventure while spending time with swimming, canoeing, horseback riding, arts and crafts, nature studies, field sports, archery, dance, drama and mime. All the typical summer camp activities are offered, plus great campfires, evening dances, and twilight programs.

All counselors are fluent in sign language and have experience working with children. The staff to camper ratio is one (1) counselor to five (5) campers for our Deaf Camp. We have a medical staff on site 24 hours a day.

There are two (2) sessions planned this year:

Session 1, 1st week camp July 25 - 30th (arriving the July 24th, leaving the 30th)
Session 2, August 1st -August 7th (arriving July 31th, leaving August 8th)

DEADLINE FOR ALL COMPLETED PAPER WORK JUNE 20TH 2011. NO EXCEPTIONS

Campers and parents, please choose the session you prefer and apply early! We are limited to the number of children that may attend each session, therefore, qualified campers are registered on a first come, first service basis until the camp sessions are filled.

Attached are a group of forms to be **completed** and returned in order to be considered. The forms are:

- Camper Application
- Information Sheet
- Health and Medical Record for Youth
- Authorization and Consent for Minor
- Angel Flight Air Transport Waiver
- **Proof of Medical Insurance (copy of card medical card)**

SUBMIT ALL COMPLETED FORMS AT THE SAME TIME

Upon receipt of all the necessary forms you will be contacted and, if your application is accepted, you will receive further information regarding the camp.
Please send **completed** forms to the **Director** address at top of this page

Name of child...

The cost is $300 per child for one week of camp.

If you can, please remit the fee with your application. If not, a Lions Club will assist you with a sponsorship. We ask that hearing siblings submit $300 along with this application. Please complete the following:

_____ MY FEE IS ENCLOSED.

_____ I CAN PAY A PORTION OF THE COSTS.

_____ I WILL SEND THE BALANCE OF $______BY ________, 2010.

_____ I NEED THE LIONS TO PAY THE ENTIRE COST AND I HAVE

_____ ENCLOSED MY SIGNED REQUEST FORM.

TRANSPORTATION

Angel Flight provides air transportation to and from camp free of charge (Due date is **June 20, 2010**.) A municipal airport will be identified close to your home. Ground transportation (limited assistance) is provided by Lions members or parents of other campers. Campers must be registered by June 15th to qualify for air transportation assistance. Please check all that apply:

_____ I request air transportation and I have completed the Angel Flight Waiver of Liability and a doctor has completed the Medical Release □ **TO CAMP** □ **RETURN FLIGHT HOME**

_____ I request ground transportation □ **TO CAMP** □ **FROM CAMP TO HOME**

_____ I can help provide ground transportation for ______ passenger's □ **TO CAMP** □ **FROM CAMP TO HOME**

In the space below, please write a few comments about your child, their reasons for wanting to go to camp, and any memorable past camp experiences.

____

____

____

____

PARENT/GUARDIAN

I agree to allow the information contained on this information sheet to be released in order to obtain sponsorship for my child.

NAME____ DATE______________________

PARENT SIGNATURE:____

DAYTIME PHONE______________________________HOME PHONE _________________________

EMAIL _______________________________________ FAX #________________________________

CALIFORNIA LIONS CAMP 2011

Spaces are limited, mail completed application to;
Director Brooke Bateman
106 E. 27th St, Merced CA 95340
Tel: (209) 769-4315 email: ilybrookeb@yahoo.com

CAMPER APPLICATION

Please fill in completely

_Is the camper: Male____________Female_______ **Circle Adult Shirt Size: SM M L XL XXL**

Campers Name: _____________________________ Birth Date: ________________ Age at Camp: _______________

Address: ____ City: ______________________________

State: _______Zip: __________ Home Phone: ______________________TTY? Yes___________No ____________

E-mail: _______________________________ (write clearly please)

Cell Phone: ____

Other Phone: ___________________________ What language is spoken in the home? ___________________________

Is there an English user at home? Yes ________No ________ If yes, who?_____________________________________

Apply for <u>ONE</u> session only:

___________ **July 25th – July 31st**
Deaf Camp Session 1

___________ **August 1st – August 8th**
Deaf Camp Session 2

Is the camper: Deaf _______________ Hard of Hearing ________________Hearing Sibling ______________________

Camper communicates using? ASL ______ PSE _______ SEE _______ Cued Speech ________Speaks _____________

Please indicate the swimming ability of your child: Beginner ________Intermediate _________ Advanced ______________

Has your child been to camp before? Yes_____ No ______ How many years? _________Name of camp: ______________

What were some of their favorite activities? ____

Attach a recent photo here please

Name of child...

Does your child have any emotional behavioral or medical conditions that the camp staff should be aware of? (Explain)

____

____

____**C**

alifornia Lions Camp Incorporated does not provide health and accident insurance for the camper. Parents must carry their own insurance for their child or be prepared to pay the cost of any medical services required while at camp. Many medical service providers require a proof of insurance at the time medical services are rendered. Please provide a sticker card or other insurance identification prior to the camper arriving at camp. If the camper is not insured or does not provide Camp Pacifica with proof of insurance, please be prepared to pay $25.00 to cover the cost of a supplemental medical insurance plan for coverage while the camper is attending Camp Pacifica. We ask that you supply us with the following information.

Insurance Company

____

Policy # ______________________________Group # ________________ Medical # __________________________

SCHOOL INFORMATION (Please complete this section)

School Attending: ____________________ Teacher's Name: ________________ Phone Number: _____________________

Address of School: _________________________City: ______________________________ State: _____ Zip:________

PARENT AND CAMPER AGREEMENT

The camper will follow camp rules and respect all individuals at camp including the campers, staff, equipment and camp property. Parents are required to pay for any damage done to personal property or camp property. Absolutely no weapons, alcohol. or illegal drugs are permitted. If the camper repeatedly disobeys any rules or displays behavior that places themselves, other campers, or staff in danger, the parents will be notified to come to Camp Pacifica and take their child home.

____ ____

Camper' Signature Date

____ ____

Parent's/Guardian's Signature Date

Before a camper may be considered, please return completed: the "Camper Application", "'Information Sheet", "Health and Medical Record for Youth", and "Authorization and Consent for Minor". Also submit the Angel Flight "Medical Release" and "Air Transportation Waiver" if you are requesting air transportation.

SUBMIT ALL FORMS AS SOON AS POSSIBLE BUT AT THE SAME TIME!
AND WELL BEFORE THE DEADLINE JUNE 20TH 2011
THANK YOU.

HEALTH AND MEDICAL RECORD

Name: ____ Date: __________

Address: ________________________________City: _______________State:____ Zip: _______

Person to contact for medical emergency

Name: ____ Relationship: _______Parent _____Guardian

Address: _________________________________City: _______________State:_______ Zip: _____

Phone: ___________________ Email: ___________________ Other Instructions: ________________

FILL OUT THIS PAGE COMPLETELY then take it to your physician or usual source of medical care (clinic, health center, etc.) for the examination.

HEALTH HISTORY

To be signed by parents of those under 18 years of age.

HAVE OR SUBJECT TO: (Check if Yes)

☐ Asthma ☐ fainting spells ☐ convulsions ☐ heart trouble ☐ diabetes (type) __________________

☐ Swimming or sport restrictions ☐ allergy or reaction to any medication ☐ other ___________________

Describe: ____

Check here if none of the above applies ☐

IMMUNIZATION	Date of Last Inoculation	IMMUNIZATION	Date of last Inoculation
tetanux toxoid	____________________	measles	____________________
polio	____________________	German measles	____________________
mumps	____________________	diphtheria	____________________

HAVE DIFFICULTY WITH: (Check if Yes)

☐ eyes, ears, nose, throat ☐ digestion ☐ bed-wetting ☐ measles ☐ chicken pox ☐ German measles

☐ lungs ☐ menstrual problems ☐ sleepwalking ☐ mumps ☐ whooping cough ☐ diphtheria

LIST ALL MEDICATIONS TO BE CONTINUED WHILE AT CAMP

Medication	Dosage	Time

Special dietary needs? ____________________________________ **Vegetarian?**____________________

Any restriction of activity for medical reasons? Explain: ____

____

PARENT AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my child.

Parent or Guardian Signature: _______________________________________ Date: ______________

NOTE: Above information and medical record on the reverse side are to be shared with adult leader and those responsible for camp and special activities including transportation.

THIS PART OF THE FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN OR PERSON LICENSED TO PROVIDE MEDICAL INFORMATION AND ASSESSMENT.

MEDICAL EVALUATION

TO PHYSICIAN: review health history. If incomplete, please ask that this essential information be provided for your use.

If health history of individual so indicates, a full examination should be performed.

SIGNIFICANT PAST HISTORY:

PART A – Use this part ONLY if applicant has had an exam within the past 2 (two) years. If not, skip to Part B.

Physician's Health Memorandum

(To be completed annually when complete physical examination is not done)

Name ________________________________ last had a medical examination on (Date) __________________
and no contraindication to their participation in any activity was found except as noted below.

Individual should be restricted from ____

Individual is susceptible (or allergic) to ____

Other instructions: ____

PART B – For use if applicant has NOT had a physical examination within the past 2 (two) years.

Physical Examination

Vision R 20/ _________ L 20/ ________ B.P. ___________With glasses R 20/ _________L 20/ ________

1. Eyes	☐	7. Thyroid	☐	12. Abdomen	☐	17. Skin (acne and scars)	☐
2. Ears	☐	8. Lymph nodes	☐	13. Hernia	☐	18. Reflexes	☐
3. Hearing	☐	9. Chest (gynecomastia)	☐	14. Genitalia (maturity)	☐	19. Pilonidal sinus	☐
4. Nose	☐	10. Heart	☐	15. Extremities (joints)	☐	20. Speech	☐
5. Throat	☐	11. Lungs	☐	16. Skeletal (scoliosis)	☐	21. Emotional adjustment	☐
6. Teeth	☐						

Required Tests: Urinalysis Sugar? ____________________ Albumin? ______________________

If indicated: Blood count _________________________ Chest plate _______________ Tine Test ___________

Should be restricted from: ____

Individual is susceptible (or allergic) to: ____

Other Instructions: ____

Physician's Assessment

This person appears to be fit to participate in:

Camping and Hiking __________ Water Sports ________ Competitive sports ________________________

This person may request transportation assistance from Angel Flight. Please confirm that this patient is medically stable and may fly in a small non-pressurized aircraft. YES ☐ NO ☐

Please indicate the applicants: Height ____________________ Weight __________

Date: _______________ Signature: ____

Address: ____

City: _______________________ State: ________ Zip: ____________Phone: _________________________

Fax: _______________________ Email: ____

CALIFORNIA LIONS CAMP

AUTHORIZATION AND CONSENT FOR MINOR
Or young person not emancipated
CCP 25.8 AND PENAL CODE SECTION 12552

________________________________ _______________________

Name of Camper **Date of Birth**

The undersigned do hereby authorize California Lions Camp Incorporated or such substitute 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 Medical Practice Act or any dentist under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, at Camp Pacifica or elsewhere. The undersigned further authorizes the California Lions Camp to use a photographic likeness of the camper in its publicity, publications, films and videos.

This authorization will remain effective while the above minor is in route to or from or involved or participating in any California Lions Camp, Incorporated program or activity, unless revoked in writing by the undersigned, and delivered to the aforementioned agent.

Date: ________________________

Father/Guardian (Signature)	Mother/Guardian (Signature)
Father/Guardian (Print)	Mother/Guardian (Print)
Address	Address
City State Zip	City State Zip
Home Phone #	Home Phone #
Work Phone #	Work Phone #
Email	Email
Fax #	Fax #