For Office Use Only: ___________Weekly Fee __________ DHS Cert. _______________Bus Stop

Camp Crosby Application

Camper's Name: Last: _______________________________ First: _____________________________

Date of Birth: Month: _____/_____/_____ Grade going in September 2019 __________ Sex: _____Male _____Female

Street Address: ____

City: ____ State: ____ Zip Code: ____________

Parent/Legal Guardian: ____

Home #: __________________Work #: ___________________ Cell/Pager #: ______________________

IN CASE OF EMERGENCY NOTIFY:

Name: ______________________________ Home #: _______________ Work #: __________________

Name: ______________________________ Home #: _______________ Work #: __________________

Parent Signature: ____ **Date:** ________________

Please check below to indicate which sessions your child will attend:

______ WEEK 1 JUNE 17 – JUNE 21

______ WEEK 2 JUNE 24 – JUNE 28

______ WEEK 3 JULY 1 – JULY 5 (Closed July 4)

______ WEEK 4 JULY 8 - JULY 12

______ WEEK 5 JULY 15 – JULY 19

______ WEEK 6 JULY 22 – JULY 26

______ WEEK 7 JULY 29 - AUGUST 2

______ WEEK 8 AUGUST 5 - AUGUST 9

______ WEEK 9 AUGUST 12 – AUGUST 16 (closed August 12)

______ WEEK 10 AUGUST 19 – AUGUST 23 at Williams Ave

Camp Crosby Health Form & Pick up Authorization

Any condition requiring regular medication?___ Name of Medication _______________________________

*Please see handbook for our policies regarding medication given at camp

Any restriction of activity for medical reasons ___ Explain ____

ALLERGIES:

Bee/Insect Stings	Y or N	Poison Ivy/Oak/Sumac	Y or N
Seafood	Y or N	Peanuts	Y or N

PARENT AUTHORIZATION

This health history is correct to the best of my knowledge, 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 injections or surgery for my child.

Parent Signature: ____ **Date:** ___________________

Please list below anyone who is authorized to pick your child up. Please note that you must call and let the office know if any of these people will be picking up and anyone picking up should have their photo id available for staff to confirm their identity:

Name	Phone	Name	Phone
___________________________	___________	___________________________	___________
___________________________	___________	___________________________	___________
___________________________	___________	___________________________	___________