

Charles Campbell Childrens Camp CAMPER APPLICATION  
Camp dates July 15-20, 2012

PO Box 23342  
Billings, MT 59104  
(406) 670-2496  
e-mail: campbellcamp@msn.com

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-Mail address \_\_\_\_\_

Has your child attended the Charles Campbell Camp before? Yes \_\_\_ No \_\_\_ Year \_\_\_\_\_

**Disability/Condition:** \_\_\_\_\_

**Communication Ability:** \_\_\_\_\_

**Physical limitations:** \_\_\_\_\_

ambulates freely \_\_\_ ambulates w/ walker \_\_\_ ambulates with crutches \_\_\_ wheelchair bound \_\_\_\_\_

Please send wheelchair with your child if he/she uses one for long outings. **No Electric wheelchairs!**

**Special Equipment Needs** (will bring to camp): Wheelchair \_\_\_ Braces \_\_\_ Feeding Equip. \_\_\_

Crutches \_\_\_ Hearing aid \_\_\_ Toileting devices \_\_\_ Walker \_\_\_ Diapers \_\_\_

Other \_\_\_\_\_

**Behavioral Issues** (tantrums, biting, self abuse) \_\_\_\_\_

Ways you handle these situations: \_\_\_\_\_

Please be honest so that we are aware of problems and can handle them in an effective manner. If we feel your child is detrimental to the other children in camp, we will call and ask that you come and get him/her. Please use separate sheet if necessary to explain or call us and we can talk about it.

**Eating:**

Special Diet/equipment/needs: \_\_\_\_\_

Eats independently \_\_\_ Favorite Foods: \_\_\_\_\_

Dislikes: \_\_\_\_\_

Other: \_\_\_\_\_

**Dressing:** Independently \_\_\_ Needs help with \_\_\_\_\_

**Bathroom:** Independently \_\_\_ Needs help with \_\_\_\_\_

What times taken to the bathroom \_\_\_\_\_

Special Needs / instructions to assist your child in their camp experience: \_\_\_\_\_

I hereby affirm that I am the parent/guardian of \_\_\_\_\_ and consent that photographs, videos, or any other Media reproduction of same taken of him/her may be used by the Camp Director, Staff, and or the Billing's Lions Club to advertise or publicize in any manner.

I give my permission to participate in the camp program sponsored by the Billing's Lions Club and release the Lions Club and the camp staff from any liability resulting from such activity.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical Information: Please include a recent picture of Child.**

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Allergies to:  
(Medications) \_\_\_\_\_  
(Food :) \_\_\_\_\_  
(Other:) \_\_\_\_\_

Prescription Medications: **PLEASE** be very specific with the dosage and times you give your child each different medication: We have included a new medication sheet for clarification. **All prescriptions need to be in the bottle they came in with instructions clearly labeled on the bottle. Please do not send pills in baggies. If the dosage or times given have changed from the bottle, you will need a doctor's prescription stating that. Also, please send a few extra, if a pill is dropped in a puddle, stepped on etc. we need to be able to replace it.**

**Over the counter meds. / Other Non-Prescription (vitamins, Tylenol, cough syrup, allergy, upset stomach etc.)**

I give my permission to the camp staff to give these OTC meds to my child for these conditions.

Med name: _____	Dosage: _____	Reason _____
Med name: _____	Dosage: _____	Reason _____
Med name: _____	Dosage: _____	Reason _____
Med name: _____	Dosage: _____	Reason _____

Other Instructions: \_\_\_\_\_

**Emergency Consent** to Treat (name) \_\_\_\_\_ for Dates \_\_\_\_\_

I hereby give my permission to any available physician or member of hospital medical staff to perform emergency medical treatment and procedures for (name) \_\_\_\_\_ as he/she deems necessary, and to continue treatment and procedures until such time as the undersigned shall dismiss or engage another physician. This permission includes admission to the local hospital if the physician deems necessary.

It is also understood that the Charles Campbell Camp, the staff, and the Billing's Lions Club are released from any liability which may be incurred,

**Parent/Guardian Signature** \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Daytime phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Contact** (if you are unavailable) Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone #'s \_\_\_\_\_

Please answer the questions below:

Physician preference \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_

Insurance carrier \_\_\_\_\_ Policy number \_\_\_\_\_

Medical conditions \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

