



## Camper's Application Form

***PLEASE PRINT LEGIBLY***

**Campers Name:** \_\_\_\_\_  
(Surname name) (Given Name) (Popular Name)

**Home Telephone:** \_\_\_\_\_ **Sex(circle one):** MALE FEMALE

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Age:** \_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_  
M D Year

**Camper's HEALTH CARD NUMBER:** \_\_\_\_\_

**School Attending:** \_\_\_\_\_ **Grade Completed by Camp Time:** \_\_\_\_\_

**Parent's/Guardians' Names:** \_\_\_\_\_  
(Exactly as they should appear on Camp records)

**Occupations:**

Mother: \_\_\_\_\_ at: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father: \_\_\_\_\_ at: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Step Parent: \_\_\_\_\_ at: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**Alternate Contact:** (in case of emergency where both Parents or Guardian cannot be reached)

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Telephone:** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

The Camp reserves the right to dismiss a camper if it is in the best interest of the camper or Camp. I desire my child to participate in the full camp program and all activities unless I advise you otherwise in writing. I agree that, having taken such precautions as in your discretion are deemed advisable, you shall not be held responsible for any accident or sickness to my child. If for any reason my child requires medical attention or special medication beyond that furnished by the camp, I agree to be responsible for any expenses incurred. Furthermore in case of an emergency and I am not available for immediate consultation, I hereby give permission to the physician selected by the CAMP DIRECTOR, to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for my child. I authorize Camp Northern Lights to use a photograph of my son/daughter in the Camp brochure or Camp displays (including but not limited to the Camp website).

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

**Indicate t-shirt size:** XS \_\_\_ S \_\_\_ M \_\_\_ L \_\_\_ XL \_\_\_

## Personal and Confidential Information:

We are interested in providing the most beneficial summer to your child. In order to accomplish this it is necessary to have as much information as possible about his/her habits, likes and dislikes. Would you please give the following questions your careful attention, and thereby assist us in helping your child and you. Indicate an ( x ) after each of the following that best describes your child:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Over Emotional  | <input type="checkbox"/> Well Coordinated          | <input type="checkbox"/> Prefers Quiet Activities   |
| <input type="checkbox"/> Athletic        | <input type="checkbox"/> Enjoys Competitive Sports | <input type="checkbox"/> Energetic                  |
| <input type="checkbox"/> Shy with Adults | <input type="checkbox"/> Shy with Others their age | <input type="checkbox"/> Moody                      |
| <input type="checkbox"/> Over Sensitive  | <input type="checkbox"/> Easy Going                | <input type="checkbox"/> Difficulty keeping friends |
| <input type="checkbox"/> Indifferent     | <input type="checkbox"/> Nervous                   | <input type="checkbox"/> Happy                      |
| <input type="checkbox"/> Aggressive      | <input type="checkbox"/> Withdrawn                 | <input type="checkbox"/> Tires Easily               |

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

What does he/she like doing most(games, hobbies, etc.) \_\_\_\_\_

What are his/her special talents? \_\_\_\_\_

Swimming Ability:  Non-Swimmer  Beginner  Average  Above average

Does your child make friends with children his/her:  Own age  Younger  Older

How would you describe his/her eating habits?  Picky  Average  Hearty

In what way do you think Camp can best help your child? \_\_\_\_\_  
\_\_\_\_\_

Any advice regarding personal habits, physical or emotional needs? \_\_\_\_\_  
\_\_\_\_\_

Has he/she any physical handicap? \_\_\_\_\_ Please describe: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any learning disabilities? \_\_\_\_\_ Please describe: \_\_\_\_\_  
\_\_\_\_\_

Does he/she wear glasses? \_\_\_\_\_ Should they be worn at all times? \_\_\_\_\_

Does he/she have any orthodontic appliance? \_\_\_\_\_ Must it be worn at all times? \_\_\_\_\_

Is he/she a habitual bed wetter/soiling? \_\_\_\_\_ Or an Occasional bed wetter/soiling? \_\_\_\_\_

Any brothers? \_\_\_\_\_ What ages? \_\_\_\_\_ Any sisters? \_\_\_\_\_ What ages? \_\_\_\_\_

Is he/she adopted? \_\_\_\_\_

Is there a divorce/separation in the family? \_\_\_\_\_ Are both parents living? \_\_\_\_\_

Who has custody of the child? \_\_\_\_\_ Is there a step parent? \_\_\_\_\_

Are there any step brothers and/or step sisters? \_\_\_\_\_

Previous camps attended: \_\_\_\_\_

Will he/she have a chance for another vacation this summer. If so please explain: \_\_\_\_\_  
\_\_\_\_\_

What does he/she wish to accomplish: \_\_\_\_\_

**Sometimes we are not able to place campers exactly where they want to be, but we do our best. If you have children of the same gender attending camp the same week, they will be put together unless the parent calls to specify otherwise.**

# Camper's Health History

PLEASE PRINT LEGIBLY

Name of Participant: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: M \_\_\_ D \_\_\_ Y \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Contact #: \_\_\_\_\_

Camper's HEALTH CARD NUMBER: \_\_\_\_\_

Date of Last Tetanus Shots: M \_\_\_ D \_\_\_ Y \_\_\_\_\_

If Camper has had any of the following, please indicate (x)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Severe Stomach Aches | <input type="checkbox"/> Hepatitis                            |
| <input type="checkbox"/> Meningitis              | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Mumps                                |
| <input type="checkbox"/> Frequent Colds          | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Fainting Spells                      |
| <input type="checkbox"/> Whooping Cough (recent) | <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> <i>Psychiatric Guidance</i> *        |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Measles, German      | <input type="checkbox"/> <i>Consulted Psychiatrist</i> *      |
| <input type="checkbox"/> Epileptic               | <input type="checkbox"/> Sleep Walking        | <input type="checkbox"/> <i>Psychologist</i> *                |
| <input type="checkbox"/> Measles, Red            | <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> <i>Professional in other field</i> * |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Diabetes             |   |
| <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Bed Wetting/Soiling  |   |

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

**Please attach a sheet of paper with details in writing for all items marked with a “\*”**

If the participant has allergic reactions to such things as food, insect stings, etc. Please complete the following.

Allergy	Life Threatening?	Allergy	Life Threatening?
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Recent Injuries, operations, illnesses: \_\_\_\_\_

Is child taking any medication? \_\_\_\_\_ If so please explain: \_\_\_\_\_

Overall Health: \_\_\_\_\_

In your opinion is there any medical reason that your child should not attend Camp Northern Lights? \_\_\_\_\_

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:

I hereby request and give permission for the Director of Camp Northern Lights and/or his delegate to administer medication or provide special services prescribed herein to my child who is named above for the duration indicated by your family Physician.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Family Doctors Name: \_\_\_\_\_ Phone #:( \_\_\_\_\_ )

# **WEST NILE VIRUS**

*What we are doing at Camp Northern Lights:*

1. Keeping abreast of all new information; maintaining regular contact with health officials
2. Checking all screening on buildings and tents and installing new screens where necessary.
3. Monitor for any standing water and correct the situation.
4. Empty any equipment that can hold water.
5. Training our staff on how to deal with the issue.
6. Encouraging the campers and staff to wear light coloured clothing.
7. Encouraging the campers and staff to wear long sleeves and long pants.
8. We have three mosquito magnets for the Camp.
9. We have purchased repellent for all campers and staff which follow the guidelines of the Ministry of Health. Repellent should contain DEET (not citronella).
10. Staff will ensure repellent is applied three times per day when required.

# **INFECTIOUS DISEASE PREVENTION**

*What we are doing at Camp Northern Lights:*

1. Everyone at Camp will be required to wash their hands and will be provided with hand sanitizer before each meal.
2. Detailed hand washing instructions will be placed at the washstand.
3. Staff will be trained on how to prevent the spread of contagious diseases in our camp environment.
4. We reserve the right to become more comprehensive and restrictive with our policies.

# **PERMISSION FORM**

I, the undersigned, hereby give permission for the administration of mosquito repellent to \_\_\_\_\_ at Camp Northern Lights.

(Camper's Full Name)

I am aware the Camp has obtained "OFF – FAMILY CARE" which has 7 % DEET and will be administered, at most, three times per day if needed.

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Parent/Guardian Signature**