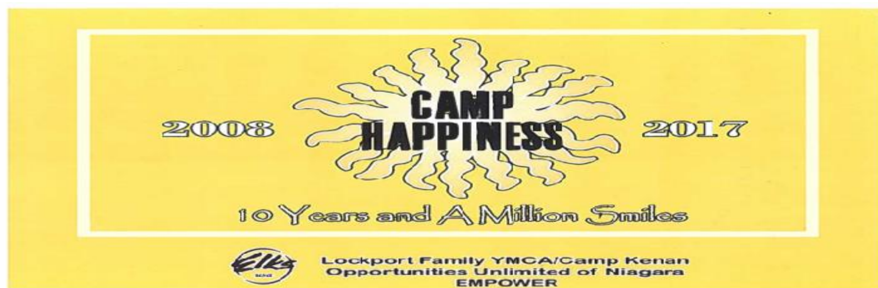

OPPORTUNITIES UNLIMITED: *NEW CAMPER*
CAMP HAPPINESS PROGRAM APPLICATION June 26th-30th, 2017

*****Cost: *Please Check:*** ☐ 1 Day - $10.00 ☐ 2 Days - $20.00 ☐ 3 – 5 Days - $25.00

Days Attending: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

***** PAYMENT FOR CAMP IS NON-REFUNDABLE *****
MAKE CHECK OUT TO OPPORTUNITIES UNLIMITED

Camper Name: ______________________________ **D.O.B.**: ______________

Parent/Family Member Name: ____________________ **Date**: ______________

Address: ____

Home Phone: __________ **Cell Phone**: __________ **Work phone**: ____________, ext. ___

Social Security #: ________________________ **Gender**: ☐ Male ☐ Female

Medicaid #: ________________________

Allergies: ____

____

Emergency Contact Person *(someone outside of the residence where they live)*:

Name: ______________________________ **Relationship**: ______________

Home Phone: __________ **Cell Phone**: __________ **Work phone**: ____________, ext. ___

Medicaid Service Coordinator / Case Manager:

Name: __________________________ **Agency**: ____________________

Work phone: ____________, ext. ________ **Cell Phone**: ____________________

Other Insurance:
Please List Carrier and Group #: ______________________________

OPPORTUNITIES UNLIMITED: ***NEW CAMPER***
CAMP HAPPINESS PROGRAM APPLICATION June 26th-30th, 2017

____

A photo copy of front and back of health insurance card must be attached to this form

Adaptive Devices *(ex., wears eyeglasses, utilizes walker, hearing aid, etc.):*

____

____

Parent / Guardian Authorization Section on Page 3 Must be Signed

Medical Status: List chronic health concerns (allergies, cardiac difficulties, asthma, any physical restrictions, seizures, avoid excessive sun exposure). Please include approximate date of last seizure.

____

____

____

____

Prescription Medications:

Medication	Form: Pill / Capsule, Suspension (liquid) Topical Cream	Times Taken	Taken With Food / Drink	Dosage

Level of Assistance: Check appropriate box

Skill Area	Independent	Reminders required	Moderate assistance	Maximum assistance
Dressing				
Bathing / Showering				
Ordering				
Hygiene				
Feeding				

Physical Restrictions for Activities *(please be specific):* ______________________________________

____

OPPORTUNITIES UNLIMITED: *NEW CAMPER*
CAMP HAPPINESS PROGRAM APPLICATION June 26th-30th, 2017

____

____

Can he / she tolerate water / swimming *(any allergies to chlorine):* ____________________________

____

____

____

Parent / Guardian Authorizations:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Opportunities Unlimited and Camp Happiness staff (Lockport YMCA) to give first aid, administer prescription medications (nurse will be present), and seek emergency medical treatment including ordering x-rays or routine tests (if necessary). I agree to the release of any records necessary for insurance purposes.

I give Opportunities Unlimited and Lockport YMCA permission to arrange necessary emergency related transportation for my child. In the event I can't be reached in an emergency I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

I authorize the use of my camper's photo/video and information specific to his / her participation in the 2016 Camp Happiness Program. ☐ YES ☐ NO

______________________________ ______________________________
Signature of Parent /Guardian Date

____
Printed Name

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

______________________________ ______________________________
Signature of Camper / Minor Date