

**Parent Authorizations and Policies**

I understand that there is a \$110 cancellation fee per week for dropping session(s) after I enroll, and that there are no refunds for camp tuition within two weeks of the session(s) in which my child/children are registered. I agree to pay the balance one month prior to the session my child is attending. If the balance is not paid, the camper's spot is forfeited and the \$110 will not be returned. If paying by credit card, I agree for the remaining balance to be charged to the credit card on file one month prior to the session my child is attending. If paying by check, I agree to pay the remaining balance by check one month prior to the session my child is attending. I understand that the camp fees do not include accident or illness insurance and Whippoorwill Farm Day Camp is not responsible for any expenses incurred and I agree to release any records necessary for insurance purposes. I give my permission for my camper to participate in all Camp activities and emergency medical care to be given if needed.

I authorize the Camp to have, use, publish, and reproduce photographs, slides, moving pictures or television video tapes for its records or public relations program. Permission is granted for the camper to participate in all planned Camp activities and programs including out-of-Camp trips by Camp transportation, overnights, canoe trips, biking trips, understanding that competent leadership will be provided. I have read the statements on the Whippoorwill price schedule. I understand and accept the Camp's policy concerning registration fees, tuition, and terms of enrollment. I also understand that once an application is accepted by the Camp, no refunds or transfer of funds will be made for withdrawal, dismissal, failure to attend, or incomplete attendance. Camp Whippoorwill is not responsible for lost items.

Camp Whippoorwill does not consider itself a camp for special needs children and is not equipped and does not charge in its normal session fees for providing any such services. Because of the nature of the summer camp expenses at Whippoorwill, the camp's ability to accommodate the special needs of children is limited at best. If the parents of children with special needs of any nature (e.g. behavioral or physical) seek to have their child be a Whippoorwill camper, the nature and scope of any special needs must be provided and reviewed by Whippoorwill before any application is acted upon. If a child with special needs is considered for camp placement, the camp may determine that the camper's special needs require additional help beyond our program capability. The camper is required to have a special qualified staff person responsible for their needs. The parents are required to pay this staff salary, in addition to the standard session fee. I understand that if full disclosure does not occur and special needs become apparent to the camp's staff, all fees paid will be forfeited and the camper dismissed.

Parent's Signature \_\_\_\_\_

**Parents' Guide**

After your camper is enrolled for sessions at Whippoorwill, visit our *Parents' Guide* on our website: [www.whippoorwill.com](http://www.whippoorwill.com). The following information will be covered: session dates and times, transportation locations and times, Whippoorwill Farm Day Camp Policies and Procedures, and much more. If you do not have internet access, we will be glad to send you a printed copy (upon request).

OFFICE USE ONLY
Date _____
_____
_____

WHIPPOORWILL FARM DAY CAMP | whippoorwill@starband.net  
7840 Whippoorwill Lane | Fairview, TN 37062 | 799-9925

# Application Form: 2010

Camper's Name \_\_\_\_\_

Sex \_\_\_\_\_ Returning Camper \_\_\_\_\_ New Camper \_\_\_\_\_

Camper's Age on June 1 \_\_\_\_\_ Date of Birth \_\_\_\_\_

School Grade (next year) \_\_\_\_\_ School Name \_\_\_\_\_

**Contact Information**

Parent's Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ FAX \_\_\_\_\_

Work Phone (mother) \_\_\_\_\_ Cell Phone (mother) \_\_\_\_\_

Work Phone (father) \_\_\_\_\_ Cell Phone (father) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

**A health history form is included with this application form, and it must be filled out and sent with the application. The shot record may be sent later, but must be received either by mail or FAX by April 1, 2010.**



# Health History Form for Children Attending Camp Whippoorwill

## This form **MUST** be signed and sent with the application for completion of registration.

PARENTS: please fill out and sign this form to be included with the camp application form when enrolling your child for summer camp sessions. Your physician's signature is not necessary. The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp upon participant's arrival in camp. Please provide complete information so that the camp can be aware of your needs. The information included on this form is confidential and is stored in the camp's infirmary to be used by the camp's staff RN for campers visiting the infirmary in the event of injury or illness.

Full name of child \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age at camp \_\_\_\_\_

2010 Camp Sessions Camper Is Attending \_\_\_1\_\_\_2\_\_\_3\_\_\_4\_\_\_5\_\_\_6\_\_\_7\_\_\_8\_\_\_9\_\_\_LC\_\_\_CIT\_\_\_

## Emergency Contact Information

CUSTODIAL PARENT/GUARDIAN

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

SECOND PARENT/GUARDIAN/ OR EMERGENCY CONTACT (please circle which applies)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information

Is the participant covered by family medical/hospital insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, indicate carrier or plan name \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Social Security number of policy holder or insurance ID number \_\_\_\_\_

## Important — must be completed for attendance:

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/ or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### Medications Being Taken

Please list (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug) the name of the medication, the dosage, and the frequency of administration.

\_\_\_\_\_ This person takes NO medications on a routine basis OR \_\_\_\_\_ This person takes medications as follows:  
Med# 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_  
Med# 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer.

### Restrictions

(The following restrictions apply to this individual.)

**Allergies and/or restrictions** (horse, cat, peanuts, etc.) \_\_\_\_\_  
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) \_\_\_\_\_

### General Questions

(explain "yes" answers below)

HAS/DOES THE PARTICIPANT	YES	NO	HAS/DOES THE PARTICIPANT	YES	NO
1. Had any recent injury, illness or infectious disease?	_____	_____	17. Ever had problems with joints?	_____	_____
2. Have a chronic or recurring illness/condition?	_____	_____	18. Have an orthodontic appliance being brought to camp?	_____	_____
3. ever been hospitalized?	_____	_____	19. Have any skin problems? (e.g. itching, rash, acne?)	_____	_____
4. Ever had surgery?	_____	_____	20. Have diabetes?	_____	_____
5. Have frequent headaches?	_____	_____	21. Have asthma?	_____	_____
6. Ever had a head injury?	_____	_____	22. Had mononucleosis in the past 12 months?	_____	_____
7. Ever been knocked unconscious?	_____	_____	23. Have problems with diarrhea/constipation?	_____	_____
8. Wear glasses, contacts, or protective eye wear?	_____	_____	24. Have problems with sleepwalking?	_____	_____
9. Ever had frequent ear infections?	_____	_____	25. If female, have an abnormal menstrual history?	_____	_____
10. Ever passed out during or after exercise?	_____	_____	26. Have a history of bed-wetting?	_____	_____
11. Ever been dizzy during or after exercise?	_____	_____	27. Have a history of encopresis?	_____	_____
12. Ever had seizures?	_____	_____	28. Ever had emotional difficulties?	_____	_____
13. Ever had chest pain during or after exercise?	_____	_____	29. Have ADD?	_____	_____
14. ever had high blood pressure?	_____	_____	30. Have AD/HD	_____	_____
15. Ever been diagnosed with a heart murmur?	_____	_____	31. Have OCD?	_____	_____
16. Ever had back problems?	_____	_____	32. Have ODD?	_____	_____

Please explain any "yes" answers noting the number of the question. \_\_\_\_\_

Which of the following has the participant had?  Measles  Chicken Pox  German Measles  Mumps  Hepatitis  
**Shot record MUST be received by April 1, 2010.** Please give date for last immunization for:

DATE	VACCINE	polio	TD (Tetanus/diphtheria)	Date of last TB Mantoux test
_____	DTP	_____	Haemophilus influenza B	_____
_____	Rubella	_____	Varicella Zoster	Result _____
_____	Tetanus	_____		

Provide information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_  
Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

**Parent/Guardian authorizations:** This Health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_