



## Camper Application

### General Information

Last Name		First Name	
SSN - -	DOB / /	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Primary Spoken Language			
T-Shirt Size	<input type="checkbox"/> Adult XL	<input type="checkbox"/> Adult L	<input type="checkbox"/> Adult M <input type="checkbox"/> Adult S <input type="checkbox"/> Child L <input type="checkbox"/> Child M
Mother's Name			
Mother's Address			
City	State	Zip Code	
Home Phone ( ) -	Work Phone ( ) -		
Cellular Phone ( ) -	E-mail		
Father's Name			
Father's Address			
City	State	Zip Code	
Home Phone ( ) -	Work Phone ( ) -		
Cellular Phone ( ) -	E-mail		

### Emergency Contacts

In the event of an emergency, please list two persons to contact who knows your child and can take full responsibility should you not be available.

Last Name		First Name	
Address			
City	State	Zip Code	
Home Phone ( ) -	Work Phone ( ) -		
Cellular Phone ( ) -	Relationship		
Last Name		First Name	
Address			
City	State	Zip Code	
Home Phone ( ) -	Work Phone ( ) -		
Cellular Phone ( ) -	Relationship		

### Medication/Health/Allergy History

Are you currently taking any medication(s)?  YES  NO  
 If yes, please specify below.

Medication	Dosage	Time	Side Effects



Medication	Dosage	Time	Side Effects
Do you have any allergies (medication, food, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list.			
Do you consent to allowing Camp Footprints to administer Acetaminophen (Tylenol) if you have a fever? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Does your child require a special diet? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain.			
Is your child up to date with his/her basic immunizations including Hib, HepB, MMR, DTP, and the Polio vaccination series? <input type="checkbox"/> YES <input type="checkbox"/> NO			

### Insurance Information

Insurance carrier (i.e. Blue Cross, Kaiser, etc.)	
Policy/Member Number	
Primary Insurance Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Other	
If other, name of subscriber	Phone (      ) -
Address	
Name of Physician	Specialty
Address	
Phone (      ) -	
Name of Physician	Specialty
Address	
Phone (      ) -	

### Parental Consent

I hereby allow the staff/volunteers of Camp Footprints permission to take and use pictures, slides and other forms of visual display of my son/daughter for the purpose of personal keepsake and promotion. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> For Keepsake Only	
<input type="checkbox"/> YES <input type="checkbox"/> NO As part of the Camp Footprints experience, may we involve your child in a well supervised swimming program?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Has your child ever been in the water?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Does your child have any fear of water?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Does your child swim and to what extent? If yes, to what extent?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Is deep water acceptable?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Is your child's ear sensitive to the water?	
<input type="checkbox"/> YES <input type="checkbox"/> NO I hereby give my permission for the staff to administer medication to our child in accordance with instructions given by our physician.	



### Authorization for Medical Care

For children under 18 and adults with court-appointed guardians:

- I/We the undersigned parent(s) or legal guardian (your name) \_\_\_\_\_ hereby authorize Roger Injarusorn, Megan Nguyen, Rei Takeda, and Pany Tehrani as agents for Camp Footprints and into those care (camper's name) \_\_\_\_\_ has been entrusted by me/us, to consent to an emergency medical and/or surgical treatment or diagnosis to be rendered to the minor under the general and special supervision and upon the advice of a Physician and Surgeon licensed under the provisions of the California Medicine Practice Act, and an emergency examination, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a Dentist licensed under the Provisions of the California Dental Practice Act. It is understood that Camp Footprints assumes no liability of any kind or character, financial or otherwise for acting pursuant to the above authorization.

Mother/Guardian Signature	Date	/	/
Father/Guardian Signature	Date	/	/

### Agreement and Signature

- I will immediately report any change in my child's health, if he/she has been sick or has taken or is taking any new medication in addition to those already reported in the medical history section.
- The undersigned certifies that all the above information is true, that he/she has read and is willing to comply with the foregoing, and the parent or guardian of the applicant, or is duly authorized to execute the above and accept its terms.
- I have read and understood the above (signatures of BOTH parents or legal guardian required).

Mother's Signature	Date	/	/
Father's Signature	Date	/	/

Please make checks payable to Camp Footprints. Amount enclosed: \$ \_\_\_\_\_

Please send a recent photograph with the application for us to keep on file.

### Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in living a life uncommon. Please send a recent photograph with this application to:

**CAMP FOOTPRINTS**  
c/o Megan Nguyen  
1107 Huntington Street  
Huntington Beach, CA 92648

## Supplemental Information

### About Your Child

Please note that the following information is crucial in our understanding of your child's needs. Please offer us a thorough explanation when necessary.

Does your child have any special interest or likes which would be motivating for him/her?

Medical Diagnosis (primary and secondary)

How does your child communicate his/her needs to others? (speech, gestures)

Does your child have any of the following? (Please check the following)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Heart Problems          |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Visual Impairments  | <input type="checkbox"/> Behavioral Difficulties |
- Please explain.

Please check the following:

Feeding:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Can feed self  | <input type="checkbox"/> Must be fed          | <input type="checkbox"/> Drinks from a bottle |
| <input type="checkbox"/> Tongue thrusts | <input type="checkbox"/> Choking difficulties |   |

Suggested techniques for feeding your child:

Sleeping: Usual hours of sleep are from \_\_\_\_\_ PM to \_\_\_\_\_ AM

- |  |   |
|--|---|
| <input type="checkbox"/> Wets bed at night       | <input type="checkbox"/> Sleeps through the night     |
| <input type="checkbox"/> Has difficulty sleeping | <input type="checkbox"/> Should have an afternoon nap |

What can we do if your child wakes up during the night?

Self Help:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Can dress self                    | <input type="checkbox"/> Can feed self | <input type="checkbox"/> Can brush teeth |
| <input type="checkbox"/> Needs full assistance in restroom |  |  |

Behavior:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> fearful          | <input type="checkbox"/> gets along well with other children                          | <input type="checkbox"/> excessive shy/withdrawn |
| <input type="checkbox"/> overly dependent | <input type="checkbox"/> is aggressive with other children (hit, bite, scratch, push) |  |

Please explain any problems or special needs.

If you have any additional comments about your child, please state them and attach additional page if necessary.