

Camper Application-2009
King's Kids' Camp

Please Print or Type

Section I. Camper Information

Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Grade (as of September 2009): _____

Previously attended King's Kids' Camp: Yes No Year(s) attended: _____

Home Church: _____ Pastor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please select date(s) attending:

() June 14 - 19 (coed 14 - 15) () June 21 - 26 (boys 11 - 13)

() June 28 - July 3 (girls 11 - 13) () July 5 - 10 (boys 8 - 10) () July 12 - 17 (girls 8 - 10)

Section II. Natural Parents Information

Marital Status: Married Single Divorced Separated

Mother's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Section III. Foster Parents Information

Foster Parents Names: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone (mom): _____ Work Phone (dad) _____

Cell Phone (mom): _____ Cell Phone (dad): _____

Section IV. Care Provider Information (complete only if foster child)

- Children & Youth Services (skip to sect V.) Contract Provider (complete sect. IV & V)

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Section V. Children & Youth Services Information

County Agency: _____ Guardianship: Yes No

CYS Caseworker: _____

Phone: _____ Cell Phone: _____ Other: _____

Section VI. Emergency Information

Emergency Contact: _____ Relation to Child: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Section VII. Parental Release

If I am unable to pick up my child I hereby authorize Kings Kids Camp to release them into the care of _____ . I understand that the camp is not responsible for any lost, stolen or damaged property. Further, I hereby give permission for the use of photographs and videos including my child in camp publicity and for my child to be transported in camp operated vehicles for approved out-of-camp activities.

Signature: _____

Please provide us with any additional information that you feel will enable us to make this a positive experience for your child: _____

.....
Reservation Deadline – May 31st
.....

Return application to: King’s Kids’ Camp, P.O. Box 68, Dillsburg, PA 17019
We reserve the right to accept or reject any application.

King's Kids' Camp Medical History

Attention Parent(s): Please complete this medical history form. Be as honest and accurate as possible. It will help us to better serve your child. This form must be completed and received by the camp with the application before a child can be accepted into camp.

Applicant's Name: _____

Birth Date: _____ Age: _____ Male: Female:

EMERGENCY CONTACT: Every effort is made to contact the parent/guardian in the event of an illness or other problem, which may require care in a medical facility. Please include two other people who know your child and should be contacted if we are unable to contact you.

Parent/Guardian: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

2nd Contact: _____ Relationship to Child: _____ Phone 1: _____ Phone 2: _____

3rd Contact: _____ Relationship to Child: _____ Phone 1: _____ Phone 2: _____

HEALTH HISTORY: (Please check the following illness that pertain)

Frequent Ear Infections <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Hepatitis <input type="checkbox"/>
Frequent Sore Throat <input type="checkbox"/>	Stomach Upset <input type="checkbox"/>	Other Drugs: _____	Date of Last Tetnus Shot: _____
Tuberculosis (TB) <input type="checkbox"/>	Constipation <input type="checkbox"/>	Communicable Diseases: (include approximate dates)	Date of Last Physical _____
Mononucleosis (Mono) <input type="checkbox"/>	Bed Wetting <input type="checkbox"/>		Chicken Pox <input type="checkbox"/> _____
Heart Defect/Disease <input type="checkbox"/>	Athlete's Foot <input type="checkbox"/>	HIV <input type="checkbox"/> _____	
Convulsions <input type="checkbox"/>	Allergies		
Diabetes <input type="checkbox"/>	Hay Fever <input type="checkbox"/>		
Bleeding/Clotting Disorder <input type="checkbox"/>	Poison Ivy <input type="checkbox"/>		
	Insect Stings <input type="checkbox"/>		

Immunizations: (Please provide dates of immunizations)

MMR _____ **Hepatitis B** _____ **Varicella (Chicken Pox)** _____ **DPT** _____

Operations, hospitalizations, or serious injuries: (Dates and causes) _____

Disability, chronic, or recurring illness: _____

Any specific activities to be encouraged or limited by physicians advice: _____

Dietary Modifications: _____

Current Medications (send original bottle with instructions): _____

Is your child taking any medication for behavioral or emotional modifications: _____

Other diseases or details of above: _____

Has menstruation begun: _____ If no, has she been told about it: _____ Any special considerations: _____

Name of Dentist/Orthodontist: _____

Name of Family Physician: _____

INSURANCE INFORMATION: (Please include a copy of your insurance or medical assistance card with this form)

Insurance Company: _____ Group Number: _____

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities except as noted above.

RELEASE OF INFORMATION: I hereby authorize King's Kids' Camp to obtain and/or release whatever educational, psychological or medical information and records deemed necessary.

MEDICAL TREATMENT: The following may be given to my child if needed (Please check all that apply):

Tylenol: External Ointment: Cough Syrup/Lozenges: None:

EMERGENCY MEDICAL TREATMENT: Further, I hereby give permission to the medical personnel selected by the camp to order X-rays, routine tests and treatment for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

Income Eligibility Instructions

1. Fill in child's name, grade and school.
2. If the child is a Foster Child check the box in section 2 and put in **THE CHILD**'s personal income, what they earn working, **NOT** what the foster parents receive for caring for the child. Write -0- if there is no personal income. Then go to section 5 have the foster parent or caseworker sign the form and enter the **CHILD**'s social security number. **NOT** the adult's social security number.
3. If the child is **NOT** a foster child and the parents receive foodstamps, FDPIR, TANF or some other government subsidized benefits program, please enter the case number on the appropriate line. Then go to section 5 have parent sign the form and enter **THEIR** social security number.
4. If the child is **NOT** a foster child and is **NOT** receiving subsidized benefits, then please fill in section 4, listing all members in the household including the camper, even if they do not earn any income. Then go to section 5 have parent sign the form and enter **THEIR** social security number.

5. SIGNATURE AND SOCIAL SECURITY NUMBER:

PENALTIES FOR MISREPRESENTATION: I certify that all information is true and correct and that the food stamp, FDPIR, TANF or other eligible program case number is current, correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the Meal Benefit Form and that the deliberate misrepresentation of the information may subject me to Prosecution under applicable State and Federal laws.

Signature of Adult: _____ Social Security Number: _____

Are you a family day care home provider applying for Tier I benefits? Y N

Printed Name: _____ Home Phone: _____ Work Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Date: _____

Privacy Act Statement: Unless you list the child's food stamp, FDPIR or TANF case number or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the form or indicate that the household member signing the form does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the form does not have a social security number, we cannot approve the form. The social security number may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits. Contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The social security number may also be disclosed to pro-rams as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigation - violations of certain Federal, State and local education, Health and nutrition programs.

6. RACIAL/ETHNIC IDENTITY: You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

- American Indian or Alaska Native Black or African American Native Hawaiian or Other Pacific Islander
 White

Please mark one of the following ethnic identities:

- Hispanic or Latino Not Hispanic or Latino

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To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington D.C. 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

For Official Use Only:

Food Stamp/FDPIR/TANF or other eligible benefit program (Tier II day care homes only) household categorically eligible free:
 Yes No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2
Total monthly income: _____ Household size: _____ Eligible: NOT Eligible:
Eligibility Classification: Free Reduced Price Paid Temporary: Free Reduced Free:
Tier I Tier II Time Period: _____

Determining official: _____

Signature: _____ Date: _____