

FSU  **Campus Recreation**
CAMP FLASTACOWO

2009 REGISTRATION & HEALTH FORM
L.I.T. Program

Camper's Name: _____
(LAST) (FIRST) (MI)

Date of Birth: ___/___/___ 08/09 Grade Completed: _____

Age at the start of Camp: _____ Gender: _____ Adult t-shirt size: _____

Mailing Address: _____

City/State: _____ Zip: _____

Name of Parent(s)/Guardian: _____

Home Phone: _____ E-mail Address(checked often): _____

Contact Information:

Mother- Work Phone: _____ Home Phone: _____ Cell Phone: _____

Father- Work Phone: _____ Home Phone: _____ Cell Phone: _____

Camp sessions: (Please **rank** the sessions in order of preference, with 1 being most preferred.)

_____ Session 1 – June 1-5 & June 8-12

_____ Session 2 – June 15-19 & June 22-26

_____ Session 3 – July 6-10 & July 13-17

_____ Session 4 – July 20-24 & July 27-31

Are there any sessions that your camper will be UNABLE to be an L.I.T.? _____

Additional Authorized Persons for Pick-up:

My child may be picked-up by the following persons (other than the above stated Parents or Guardians):

Name/Daytime Number: _____

Name/Daytime Number: _____

Person to Notify in an Emergency:

Person/Relationship _____ Phone Number _____

Person/Relationship _____ Phone Number _____

Person/Relationship _____ Phone Number _____

Health History: (Please, check appropriate box and give dates of last occurrence.)

	No	Yes		No	Yes	Date
Allergies	()	()	Ear Infection	()	()	_____
Asthma	()	()	Rheumatic fever	()	()	_____
Hay fever	()	()	Convulsions	()	()	_____
Ivy Poisoning	()	()	Diabetes	()	()	_____
Insect Stings	()	()	Hyperactivity	()	()	_____
Penicillin	()	()	Fainting	()	()	_____
Aspirin	()	()	Sinusitis	()	()	_____
Headaches	()	()	Epilepsy	()	()	_____
Frequent Colds	()	()	Behavior Disorders	()	()	_____
	No	Yes	Date			
Chicken Pox	()	()	_____			
Measles	()	()	_____			
Mumps	()	()	_____			
Bleeding	()	()	_____			
Clotting	()	()	_____			
Hepatitis A	()	()	_____			
Hepatitis B	()	()	_____			
Constipation	()	()	_____			
Bronchitis	()	()	_____			
Kidney trouble	()	()	_____			
				Other:	_____	

Details of Above: _____

Previous Operations/Serious Injuries: _____

Chronic or recurring illnesses: _____

Medications: (Please answer yes or no)

May your camper be given:

- | | |
|--------------------------------------|----------------|
| ___ Sunscreen to apply? | ___ Aspirin? |
| ___ Benedryl or other antihistamine? | ___ Ibuprofen? |
| ___ Insect repellent? | ___ Tylenol? |
| ___ Nemtrol for upset stomach? | |
| ___ Imodium AD for diarrhea | |
| ___ Anti-Bacterial Cream? | |

Family Physician and Phone Number: _____

Does your child have any allergies to medications, foods, the environment or, specifically, insect bites or bee stings?
YES or NO. If YES, please specify: _____

Please note if your child has a physical disability, has been exposed to any communicable diseases in the past 30 days, or has any special medical considerations.

Please list ALL medication the camper will bring to camp. Name of drug, dosage, time taken, condition, and possible side effects (All medication is required to be in the original, marked bottle signed by the child's physician):

Immunization History: (Please list date to the best of your knowledge)

- | | | |
|------------------------------|------------------------|-------------------|
| ____ DTP Series | ____ Small Pox | ____ Other: _____ |
| ____ Measles/Mumps/Rubella | ____ Chicken Pox | _____ |
| ____ Hepatitis B | ____ Typhoid | _____ |
| ____ Haemophilus influenza B | ____ Polio OPV (sabin) | _____ |
| ____ Tetanus Booster | ____ TB Skin Test | _____ |
| ____ BCG | ____ Polio Booster | _____ |

Proof of Insurance:

Insurance Company Name: _____
Policy #: _____
Insurance Company Phone: _____

Required Authorization
For Care of Minors Under the Age of 18

In the event of serious injury or the need for medical attention, I, _____, the parent guardian of _____ give the Camp Flastacowo staff and administration permission to: Dispense medications noted above and brought to camp by parent/guardian. In an emergency, I understand that all reasonable efforts will be made to contact me, but failure to make contact will not prevent emergency treatment necessary to help preserve life or health. I give permission to the staff and administration of Camp Flastacowo to secure proper treatment, hospitalize, and to order injection, and/or anesthesia, and/or surgery for my child. This form has been truthfully completed to the best of my knowledge, I understand my child cannot attend camp without all necessary information being provided, and I freely consent that this information can be used for my child's registration, treatment, and care.

Signature of Parent/Guardian Date