

Registration Fees
 \$30 for first child
 \$25 each additional child
 \$70 max per family
 Scholarships available,
 call for more info.

Schoharie Valley Community Camp 2017 Camper Registration Form

Office Use Only
 Payment Method: _____
 Amount: _____

Camper's Name: _____

PARENT/GUARDIAN INFORMATION

First Name:	Last Name:	Family Church Affiliation:
Mailing Address:		How did you hear about camp?:
City:	State:	ZIP Code:
E-Mail Address:		
Home Phone: ()	Cell Phone: ()	Daytime Phone: ()

CAMPER INFORMATION

Birthdate: / / month day year	Age:	2017/2018 Grade:	Gender: M F	Name to Appear on Nametag:
School:	*Name of Requested Buddy:			
*Buddy requests will be honored if possible. Because of how campers are grouped, they should be of the same age/grade but do not have to be of the same gender.				
T-Shirt Size: YXS(2-4) YS(6-8) YM(10-12) YL(14-16) YXL(16-18) AS(36") AM(40") AL(44")				

SIGN OUT & EMERGENCY CONTACT INFORMATION

List of all people approved to sign out camper:	Emergency Contact (if parent/guardian unavailable):
	Emergency Contact Daytime Phone Number: ()

INSURANCE INFORMATION & MEDICAL HISTORY

This section must be completely filled in before the application can be processed. If something does not apply to this camper, please indicate this by writing N/A in the appropriate blank. It is recommended that each camper receive a medical examination within 12 months of the beginning of camp.

Insurance Provider:	Identification Number:	Group Number:
Primary Care Physician:	Physician's Phone Number: ()	
Date of Last Tetanus Vaccination: / /	Current Medication(s):	
Circle conditions that apply to this camper: Environmental Allergies ADD Fainting Food Allergies ADHD Special Diet Medication Allergies Learning Disabilities Asthma Insect Allergies Physical Limitations Other	Give a detailed explanation for each condition circled (e.g. allergy triggers, inhaler, dietary restrictions, etc.) and instructions for nurses if medication will be administered during camp:	

RELEASE INFORMATION & SIGNATURE

My signature below certifies and gives permission that: (1) All information given is correct; (2) Photos and videos of my child can be used in camp publicity; (3) My child's medical records can be released in case of illness/injury; (4) In the event that I cannot be reached, the Physician selected by the Camp Director has permission to hospitalize, select treatment for, order medications, anesthetize, and/or perform surgery on the child named above.

Parent/Guardian Signature: _____ Date: _____

Questions? Visit: schohariereformedchurch.org or Call: (518)295-8177 or E-Mail: schohariereformedchurch@yahoo.com

Make checks payable to "Schoharie Reformed Church"

Mail completed registration form and payment to:

Schoharie Valley Community Camp | P.O. Box 635 | Schoharie, NY 12157

Enclosed is an additional
 donation of \$ _____