*****REGISTRATION DEADLINE: SUNDAY, JULY 2ND**

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

Schoharie Community Day Camp 2017
Camper Registration Form

Camper's Name: _____

Office Use Only
Payment Method: _____
Amount: _____

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: ( )

EMERGENCY CONTACT & SIGN OUT INFORMATION

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

INSURANCE INFORMATION

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: ( )	

CAMPER INFORMATION

Name to Appear on Nametag:	Gender: M F	Age:	Birthdate: / / month day year	2017/2018 Grade:
School :	T-Shirt Size: YXS(2-4) YS(6-8) YM(10-12) YL(14-16) YXL(16-18) AS(36") AM(40") AL(44")			

*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.

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.

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: schoharieformedchurch.org or Call: (518)295-8177 or E-Mail: schoharieformedchurch@yahoo.com
Make checks payable to "Schoharie Reformed Church"
Mail completed registration form and payment to:
Schoharie Community Day Camp | P.O. Box 635 | Schoharie, NY 12157

Enclosed is an additional donation of $_____