

Youth Camp Juliena 2010

July 18th – 24th, ages 6 – 12

Registration Form

Name: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Email Address: _____

Deadline for Registration Form and Registration Fee: May 14, 2010

If you need more time to complete the application, you can send this registration form now and send the rest of the application by June 11th, 2010

T-Shirt Size (Circle One): **Child:** S M L **Adult:** M L XL XXL

_____ Please send me an application

_____ Application is enclosed

_____ \$20 Registration fee is enclosed *registration fee holds your camper's spot at camp*

_____ \$210 Camp Fee for Youth Camp is enclosed

_____ Financial Aid request form is enclosed

_____ Willing to provide transportation for other campers in my area

Parent/Guardian Signature

To reserve your space at Camp Juliena, send Registration Form to:

Camp Juliena
Georgia Council for the Hearing Impaired, Inc.
4151 Memorial Drive, Suite 103-B
Decatur, Georgia 30032

For information, please contact campjuliena@gmail.com
Or call Bonna at (770) 856-2492

Youth Camp Julienna

Camper Application - 2010

-Please Print-

Camper's name:	Sex: M F	Date of Birth:	
Address:			
City:	State:	Zip Code:	County:
Home Phone: ()	Cell Phone: ()	Work phone: ()	
Email address:			
Parent's/Guardian's Name:			
Camper's School:			
Degree of Hearing Loss: (Check one) <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of Hearing			
Age of Onset:			
Cause of Hearing Loss:			
Use a Hearing Aid?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cochlear Implant			
How Did You Learn About Camp?			
Activities Which Child Can Participate In (check):			
Swimming	Hiking	Canoeing	Field Sports
What activities can your camper NOT participate in?			
Activities Encouraged:			
Activities Discouraged:			
Is Your Child Currently Taking Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*if yes, please provide instructions on pages 3 & 5			
Special Diet:			
Additional disabilities or special needs:			

Camp fees: The cost for camp is \$230.00 (if you paid the \$20 registration fee, the remaining fee is \$210.00)

I will attend camp! (\$_____ is enclosed) Please make checks payable to Camp Julienna.

If you are unable to pay and would like to apply for financial aid, please complete page 6.

Cancellation and Refund Policy: Upon request, 75% will be refunded if canceled up to three (3) weeks prior to camp. No refunds after that time.

Parent/Guardian Pledge and Signature: By signing this form, I hereby give permission for my son/daughter/charge to attend Camp Julienna at Camp Viola. I affirm that he/she is physically able to care for himself/herself, is able to participate in regular camp activities, and is of high moral standing. I also understand that my son's/daughter's/charge's picture/video may be used in promotional materials such as brochures, newsletters, and videos. I understand that neither Georgia Council for the Hearing Impaired nor Camp Viola will be liable for any illness, injury, or accident.

Camper's Signature: _____ Date: _____

Parent's/Guardian Signature: _____ Date: _____

Camp Julienna

Emergency/Medical Information

-Please Print-

Camper's Name:		Social Security No:			
Age:	Weight:	Height:	Color of Hair:	Color of Eyes:	
[] Medical/Hospital Insurance		[] Medicaid		(Please enclose a copy of insurance card or Medicaid)	
Name of Insurance:			Policy/Group No:		
Required: If Parent or Guardian not available in an emergency, notify:					
Name:			Relationship:		
Home phone: ()		Cell phone: ()		Work phone: ()	
Health History	Yes	No	Allergies	Yes	No
• Frequent ear infections			• Hay Fever		
• Heart defects/disease			• Poison Ivy		
• Convulsions (seizures)			• Poison Oak		
• Diabetes			• Insect Sting - severe reaction		
• Asthma			• Food Allergies		
Explain any "yes" item:			• Drug Allergies		
			List food allergies:		
Childhood Diseases	Yes	No			
• Chicken Pox					
• Measles			List drug allergies:		
• German Measles					
• Mumps					
Other Diseases or Disorders:					
Operations/Serious Injuries (dates):					
Additional Disabilities:					
Physical Limitations:					
For Girls: Menstruation	Yes	No		Yes	No
Has she menstruated?			If so, is her menstrual history normal?		
If not, has she been informed about it?			If not, explain on the back of this page		
Name of Medication	Dose	Frequency of Administration		Route of Administration (how given)	

Parent's/Guardian's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted by me. I hereby give permission to the Physician selected by the Camp Director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in any emergency, I hereby give permission to the Physician selected to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I understand Camp Viola, Camp Julienna, nor Georgia Council for the Hearing Impaired, Inc. are liable for any illness, injury, or accident of a camper or visitor.

Signature: _____ Date: _____

Camp Julienna

Physician's Recommendations and Restrictions While in Camp

If a Camper requires special diet (other than simple dietary change) or prescription medications while at camp, the information below must be completed by a Physician.

Camper's Name: _____

Special Diet:

All prescription drugs and medications must be in their original containers and must be turned over to the staff at check in time.

Prescription Medications to be administered at camp:

Name of Medication	Dose	Frequency of Administration	Route of Administration

Activities which child can participate in (check) :

Swimming	<input type="checkbox"/>	Hiking	<input type="checkbox"/>	Canoeing	<input type="checkbox"/>	Field sports	<input type="checkbox"/>
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Activities which child cannot participate in (list):

Does this person have any communicable diseases? [] No [] Yes (please list and explain on back)

Date of last visit: _____

This person herein described is under my care and in my opinion this person is physically able to engage in camp activities, except as noted above.

Physician: _____ Date: _____

Telephone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Mail or fax to:

Camp Julienna

GA Council f/t Hearing Impaired, Inc

4151 Memorial Drive, Suite 103-B

Decatur, GA 30032

Fax: (404) 299- 3642

Camp Julienna

Financial Aid Request Form

Please keep in mind that GACHI receives a limited amount of donations to provide camper scholarships. If your child receives a scholarship but is not able to attend camp, please contact us immediately.

Camper name: _____

Check one: _____ Teen camper (total cost is \$400)

_____ Youth camper (total cost is \$230)

Parent/Guardian name: _____

County of residence: _____

How much can you pay? _____

Please give us a brief explanation of your family's current situation and why your child deserves a scholarship:

If you accept scholarship money, but do not bring your child to camp, you may be asked to pay back the money.

Signature: _____

For office use only	Amount approved _____	Supervisor _____	Date _____
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