HELP ONE CHILD's

Signs of Hope Camp

Send Application to:
Help One Child
858 University Avenue
Los Altos, CA 94024
Attention: ***Judy Holmes***

Sunday, August 6th – Thursday, August 10th 2017

Mission Springs' Frontier Ranch

CAMPER REGISTRATION FORM

Instructions: *Please save and email to Judy Holmes.*
This form must be completely filled out. The information is vital to the health and well being of the child. Your application will be returned to you if it is not completed.
If you have any questions, please call Judy Holmes, Director of Support Services at **650-917-1210.**

Child's First Name_____ Last Name_____

Street_____ City_____ Zip_____

Sex_____ Birth Date_____ Age_____ Emotional Age_____ Grade in Fall 2017_____

The child is living with:(**check one**) ❑Foster Parent(s) ❑Group Home ❑Relative(s) ❑Adoptive Parents ❑Birth Parents

Name of Primary Caregiver:_____ Home Phone:_____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Name(s) of person(s) the child is living with including siblings: _____

_____

_____

Emergency Contact:_____ Relationship to Child:_____ Phone: _____

Social Worker:_____ County: _____ Phone: _____

Email: _____ Alternate Phone: _____

Has the child attended Signs of Hope Camp before? ❑Yes ❑No If yes, when? _____

Explain any unusual family circumstances that make camp especially important for the child
(for example: recent crisis, being moved in foster placement, etc.)

_____

_____

T-Shirt/Sweatshirt Size: ***(CIRCLE ONE)*** Child Small / Child Medium / Child Large / Adult Small / Adult Medium / Adult Large

Swim Suit Size: ***(CIRCLE ONE)*** Child Small / Child Medium / Child Large / Adult Small / Adult Medium / Adult Large

Shoe Size: (be specific, i.e. boys/girls OR men's/women's) _____

Favorite Color: _____

Child's Name _____

CAMPER'S EMOTIONAL/BEHAVIORAL HISTORY

	Often	Sometimes	Never		Often	Sometimes	Never
Aggressiveness	❑	❑	❑	Night Terrors	❑	❑	❑
Bedwetting	❑	❑	❑	Nightmares	❑	❑	❑
Biting	❑	❑	❑	Runs Away	❑	❑	❑
Eating Disorders	❑	❑	❑	Sexual Acting Out	❑	❑	❑
Hyperactive	❑	❑	❑	Steals	❑	❑	❑
Learning Disabilities	❑	❑	❑	Tantrums	❑	❑	❑
Lying	❑	❑	❑	Withdrawn	❑	❑	❑
Moved In Foster Placement	❑	❑	❑				

Does your child require one-on-one supervision? ❑Yes ❑No

Please explain including typical disciplinary measures if applicable: _____

_____

_____

_____

CAMPER DETAILS:

Name of School:_____ School District:_____

Exact date when child starts back to school in the fall:_____ IMPORTANT!!!

Reading Level:_____

Learning Disabilities: ❑Yes ❑No If yes, please explain:_____

_____

_____

_____

What is the primary language spoken at home?_____

This child's swimming ability is: ❑ Good ❑ Poor ❑ Unknown

Any specific activities to be encouraged?_____

_____

_____

_____

Any specific activities to be restricted?_____

_____

_____

_____

Child's Name _____

HEALTH HISTORY

Doctor's Name:_____ **Phone:**_____

Indicate date of illness, severity, complications, and any residual impairment.

❑ Respiratory Problems	❑ Hypoglycemia	❑Musculoskeletal Allergies
❑ Heart or Circulation	❑ Dizzy Spells	❑Foot Problems
❑ Pulmonary Edema	❑ Back Problems	❑ Seizure Disorders
❑Hay Fever	❑Anaphylactic Shock	❑ Poison Oak
❑ Balance Problems	❑Diabetes	❑ Fainting
❑Insect Bites	❑Drug Allergy	❑ Other _____

Details regarding above:_____

_____

_____

_____

Indicate any known allergies, illness, special needs, or physical limitations.

Allergies _____

_____

_____

Illnesses _____

_____

_____

Special Needs / Limitations_____

_____

_____

❑ Leg or Arm Braces ❑ Hearing Aids ❑ Wheel Chair ❑ Other: _____

IMMUNIZATION HISTORY:

Please fill in dates of basic immunizations and most recent booster MUST HAVE DATES TO ATTEND CAMP!

DTP Series Booster_____ Tetanus Booster_____

Polio OPV (Sabin)_____ Tuberculin (TB) Test _____

Measles Vaccine (live)_____ Typhoid _____

German Measles (Rubella)_____ Mumps Vaccine (live)_____

Small Pox_____

MEDICATIONS:

******All medication sent to camp must be in original container with the pharmacy label on it, and will be held and administered by the nurse******

Is your child taking any medications? ❑ Yes ❑ No
If yes, PLEASE CLEARLY complete the following:

Medication_____ Dosage:_____ Times:_____

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Medication_____ Dosage:_____ Times:_____

Medication_____ Dosage:_____ Times:_____

What is/are the medication(s) for? _____

******Please add any additional comments related to HEALTH and MEDICATIONS below.***

CONSENT:
The information contained herein is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted. The undersigned does hereby authorize the directors of Help One Child's Signs of Hope Camp or such substitute as they may designate as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is enroute to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to Help One Child.

Signature:_____ Print:_____

Relationship to child:_____ Date:_____