

Jim Eaton Summer Reading Program
K-2 CAMPER APPLICATION

PLEASE RETURN APPLICATION TO: Mail: Eaton Camp Program Office: 100 Genesee Street, Lockport, NY 14094
Fax: 716-433-3405 Email: Administrator@gracechurchlockport.com Call 716-433-2878

QUESTIONS?? Please contact Leann McConchie as noted above! THANK YOU!!

Tuition for the full **5-week program** is \$100; Do you need a scholarship? Y N
Child care after 2PM, is available at \$5 per hour through 6:00 PM Do you need child care? Y N

Camper Name: _____ Nick Name: _____
Sex: M F Age: _____ Date of Birth: _____ Grade: _____ School: _____
Home Address _____ City: _____, NY, Zip: _____
Camper Shirt Size: Youth Small Youth Medium Youth Large Youth X Large
(pick one) Adult Small Adult Medium Adult Large Adult X Large

Parent/Guardian: _____ Relationship: _____
Phone: Home _____ Cell _____ Work _____
Email: _____

In Case of Emergency - *We will need to be able to locate you or an emergency contact at any the during the camp day.* Please provide information for 2 Emergency Contacts:

1) Name: _____ Relationship: _____
Phone: Home _____ Cell _____ Work _____
2) Name: _____ Relationship: _____
Phone: Home _____ Cell _____ Work _____

How did you hear about the Eaton Program? School Faith Community Website Neighbor
 Other: _____

Consent & Release of Liability:

In case of medical emergency, I understand every effort will be made to contact a parent or legal guardian. In the event, one cannot be contacted, I hereby give my permission to the dentist or physician designated by the staff to hospitalize, secure appropriate treatment and/or order and injection, anesthesia, or surgery necessary for this child.

I hereby give permission to the representatives of the Diocese of Western New York, as a part of the reading program in 2018 to transport my child in private automobiles and/or vans. I realize that paid diocesan staff as well as volunteers may operate private vehicles. I hereby release and waive any claim I may have for injuries to said minor child including claims for medical treatment expenses for said minor child against any such person and the Diocese for their failure to exercise due care in transportation to and from and participation in any special trips. I do not waive or release claims that may arise from intentional, wanton, or willful misconduct by such staff or volunteers.

I give permission for quotes and/or photographs taken during the program to be used in promotional materials.
I give permission for my child to join contests based on reading and writing achievement.
I give permission for data regarding my child's educational attainment to be collected and shared.
I give permission for my child's past educational attainment data to be shared with representatives of the Eaton Program.

The Eaton Program retains the right to enforce its rules, and if necessary, send home any child infringing on the rights of others or whose behavior/actions are otherwise unacceptable.

The health history as well as the information on the original registration form is correct, to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

[continue on reverse side]

Health History

Medication Allergies:

Describe reaction and management of the reaction

Food Allergies:

Describe reaction and management of the reaction

Other Allergies (insect stings, hay fever, animal dander, etc.):

Dietary Restrictions

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Does not eat nut products | <input type="checkbox"/> Other**: _____ | |

Date of last physical exam: _____ (WITHIN 12 Months of program attendance)

Date of **Last Tetanus** shot: _____

Medications used at present**: _____

Dosage/s: _____ When taken: _____

MEDICAL DIAGNOSES

(Attach additional sheets with this information to the back of form if needed. Thank you!!)

Has the child had the following vaccinations: DPT, MMR, chicken pox? YES _____ NO _____

Is this child challenged in any way physically, mentally or emotionally? YES _____ NO _____

If YES, please specify _____

Has there been any trauma in the child's life, either physical or emotional? YES _____ NO _____

If YES, please specify _____

Family Dentist: _____ Phone: (____) _____

Family Physician: _____ Phone: (____) _____

Health Insurance Company: _____ Phone: (____) _____

Policy/Group Number: _____

Is there anyone legally restricted from seeing this child? Yes No If yes, name: _____

Health issues	[Yes]	[No]	Childhood diseases (approx. dates)	Other Allergies	[Yes]	[No]
Frequent ear infections	___	___	Chicken pox _____	Hay Fever/Seasonal	___	___
Heart defect/disease	___	___	German measles _____	Poison Ivy	___	___
Seizures/convulsions	___	___	Measles _____	Insect Stings	___	___
Diabetes	___	___	Mumps _____	Drugs not listed above:	___	___
Bleeding/clotting D/O	___	___	Other diseases:	_____	___	___
Hypertension	___	___	Hepatitis _____	_____	___	___
Cancer	___	___	Mononucleosis _____	_____	___	___
Epilepsy	___	___	Other: _____	_____	___	___
Cerebral Palsy	___	___	_____	<u>SURGERIES & Dates:</u>	___	___
Headaches/migraines	___	___	_____	_____	___	___
Positive HIV test	___	___	_____	_____	___	___
Other	___	___	_____	_____	___	___
Please Describe: (all "yes" answers)**						

IMPORTANT: If this child has **ASTHMA** (exercise induced or otherwise) (s)he **MUST** either bring a rescue inhaler with them **OR** a letter from their **HEALTH CARE PROVIDER** stating they **DO NOT NEED** (NOT "do not have") a rescue inhaler. Should they not have this with them at the time of registration, the child **shall be sent home**. **NO EXCEPTIONS.**

Those taking medication: Please provide medication **in plastic, daily dose containers** with medication for the day already dosed. Please place containers in a **zip-lock plastic bag clearly marked** with the **child's name**. Name of medication and dosage, for informational purposes, can be enclosed written on an index card. This will assure greater dosing accuracy for your child. Thank you!

** Please use an additional sheet of paper if necessary!