Delmarva Baptist Fellowship
Camp Program

Junior Camper Application
8 years old – 6th Grade

All campers are required to complete and sign this application form. The information will be used to help the camp directors provide a safe and secure environment for all campers who are participating in this years camp program. The material contained in this application will be shared only with those who have a genuine need to know in order to carry out their responsibilities at Delmarva Camp or as required by law. Parents are required to sign and initial in appropriate places.

Camper Information (please Print)

Name: _____ Home Phone: (_____)_____

Address: _____

City: _____ State: _____ ZIP: _____

E-Mail: _____

Male: _____ Female: _____ Date of Birth: _____

Grade Next Fall: _____ Tee Shirt Size: _____

Has camper camped with us before: _____ Has camper spent time away from home: _____

Church Information

Home Church: _____

If you died today, would you go to heaven? Yes _____ No _____ Not Sure: _____

Parental Information

Name of Parent or Guardian: _____

Phone Number during camp week: Day (_____) _____ Night (_____) _____

Cell Phone: (_____) _____ E-Mail: _____

Camper (Please Print)

Name _____

Food Allergies

Food Allergies:	Describe reaction and management of the reaction
_____	_____
_____	_____
_____	_____

Allergies

Other Allergies – Include plant, animal, insect, asthma, etc

_____	_____
_____	_____

Restrictions – List all that apply

Dietary	Activities
_____	_____
_____	_____
_____	_____

Medical Release

Camper (Please Print) Date ____/____/____

Name _____ Home Phone (____)_____

Address _____
Street or PO Box City State/Province ZIP Code

Age: _____ Date of Birth ____/____/____ Sept 2009 Grade in School ____

☐ Male ☐ Female

Parent or Guardian

Name _____

Emergency Phone (____) _____ Work Phone (____) _____

Address _____
Street or PO Box City State/Province ZIP Code

Health Insurance

Company _____ (____)_____

Policy Number _____

Physician

Name _____ Phone (____) _____

Address _____
Street or PO Box City State/Province ZIP Code

My child may be given over-the-counter medications as needed except for the following (please check those medications which **cannot** be given)

☐ Tylenol	☐ Saline, Visine eye drops	☐ Benadryl
☐ Motrin	☐ Ear drops for swimmer's ear	☐ Hydrocortisone ointment
☐ Tums	☐ Sudaphed	☐ Other _____

Medications

Name of Medication When Administered

_____ _____

_____ _____

_____ _____

_____ _____

Medical Allergies: Describe reaction and management of the reaction

_____ _____

_____ _____

_____ _____

Physical handicaps, disorders, or illnesses: _____

_____

Date of Tetanus booster (should be current): _____

All medication must be in the ORIGINAL container with the camper's name and Doctor's name on the bottle. All medication must be turned into the camp nurse on the first day of camp, no exceptions. Parent's or Guardians Initials _____

List any important medical information that is important:

I give my permission for my child to receive emergency medical treatment if I cannot be reached after a reasonable amount of time.

_____ _____

Parent or Guardian's Signature **(Required)** Date