

Lime Hollow Nature Center
338 McLean Road, Cortland, NY 13045
Tel. / Fax 607.662.4632
www.limehollow.org / E:info@limehollow.org

Please Circle Week(s)

1 2 3 4 5 6 7 8 9 10

Parents: Please complete, sign and return application with a deposit of 50% of cost of camp.

CITs Name: _____ **M** **F** (circle one) **T-Shirt Size** _____
Age: _____ **Birth date:** _____ **Grade** _____ **Member: Y or N** (circle one)
Parent/Guardian: _____ **Phone(h)** _____ **Cell** _____
Parent/Guardian: _____ **Phone(w)** _____ **Cell** _____
Address: _____
Email: _____

*Lime Hollow respects your privacy. All information we obtain is kept confidential.

EMERGENCY CONTACT, in the event the parent/guardian cannot be reached:

Name: _____ **Phone:** _____ **Cell** _____
Address: _____ **Relationship:** _____

HEALTH HISTORY, please check giving approximate dates or current status:

Hay Fever _____	Hepatitis _____	Heart Murmur _____
Poison Ivy _____	Measles _____	Chronic / Recurring Illness _____
Insect Stings _____	Rheumatic Fever _____	Penicillin Allergy _____
German Measles _____	Influenza Type B _____	Fainting _____
Mumps _____	Diphtheria _____	Food Allergies _____
Diabetes _____	Seizures _____	Operations/Serious Injuries _____
Chicken Pox _____	Asthma _____	Other drug allergies _____

Please list details of above and any physical condition or activity restrictions that should be known to staff: _____

Is this camper under medical care for any reason? () Yes () No

If 'Yes' please specify: _____

Does camper regularly take any medication? Please specify: _____

Medication (including non-prescription) must be given to Camp Director by parent/guardian on the first day of the session.

IMMUNIZATION HISTORY, in order for campers to attend camp, the parent/guardian must list specific dates for each of the following immunizations. Failure to document these dates are grounds for non-acceptance of camper registration.

DPT _____	Booster _____	Polio (IPV or OPV) (Sabin) _____	Booster _____
Varicella (Chickenpox) _____		Haemophilus influenza type b (Hib) _____	
Measles, Mumps and Rubella (MMR) _____		Hepatitis B _____	
Other _____			

Child's physician _____ **Phone** _____

TO BE COMPLETED BY PHYSICIAN: Only if your child has a serious illness or has had surgery within the last year. In this case, he/she must have this signed permission to attend camp.

Signature of Licensed Physician _____ **Date** _____

PARENT/GUARDIAN AUTHORIZATION:

This health history is correct so far as I know, and the person herein described has permission to participate in Lime Hollow's Summer Adventure Day Camp. I also authorize the following:

* I give permission for my child's photo to be used in promotional/educational/social media.

* In an emergency, when the undersigned or other named person cannot be contacted, I hereby authorize the Camp Director to take any action deemed necessary for the best interest of my child.

* The Camp attempts at all times to run programs that are educational, enjoyable and safe and further the charitable objectives of the Camp. Nonetheless, participants must understand that some of the activities of the Camp may involve inherent risks and hazards for which the Camp cannot be held responsible. Because of the nature of camp activities, injuries may still result even after reasonable precautions have been taken but it is acknowledged that the Camp cannot be held responsible in the event that injury occurs. The undersigned represents that it knows of no legal, physical or health reason why the participating child cannot fully participate in the registered program. It is also the parent's responsibility to update Lime Hollow with any changes prior to the start of camp.

Signature of parent/guardian _____ **Date** _____