SUMMER FUN FOR 4TH–6TH GRADE KENTUCKY STUDENTS

KENTUCKY DEPT. OF FISH & WILDLIFE RESOURCES

CAMP WALLACE

Lake Cumberland

SUMMER 2015

APPLY BEFORE APRIL 15

(SPOTS FILLED ON A FIRST-COME, FIRST-SERVED BASIS)

Register online for a $10 discount!
($225 final cost)

COST: $235

INCLUDES TRANSPORTATION, CAMPER INSURANCE AND JUNIOR SPORTSMAN'S LICENSE

Activities:

- Nature
- Outdoor Survival
- Archery
- Boating/Canoeing
- Swimming
- Gun Safety
- Fishing/Casting

Earn your Hunter Education 'orange card'

CAMP EARL WALLACE
KENTUCKY DEPT. OF FISH & WILDLIFE RESOURCES

REGISTER ONLINE AT:

FW.KY.GOV

OR CALL 1-800-858-1549

CAMP EARL WALLACE

HEALTH HISTORY MUST BE COMPLETED FOR ATTENDANCE

(No information provided herein shall be released, as it is exempt under the provision of the Open Records Act. See KRS 61.878.)

(Please print)

Camper's name *(Last, First, MI)*: _____ ☐ M ☐ F SSN: _____ Date of birth: _____

Address: _____ City: _____ ZIP: _____ County: _____

School: _____ Grade: _____

Parent/Guardian: _____ E-mail: _____

Parent phone numbers *(Home)*: _____ *(Work)*: _____ *(Cell)*: _____ *(Other)*: _____

Emergency contact name: _____ Relation to camper: _____ Phone: _____
(other than parent)

General Health History

Ear infections	Y N	Heart disease	Y N	
Chronic or recurring illness	Y N	Activities limited by physician?	Y N	
Hospitalization	Y N	Dietary restrictions?	Y N	
Operations/serious injury	Y N	Vaccines up to date?	Y N	
Fainting/dizziness	Y N	Date of last tetanus: _____		
Seizures/convulsions	Y N	Date of last physical: _____		

Allergies

Food: _____

Drug/Medicine Allergy: _____

Insects: _____

Other: _____

Asthma: _____

Mental/Emotional/Social Health

Psychiatric counseling/hospitalization Y N

ADHD Y N

Eating disorder Y N

Current Medications

(send in original container with instructions) _____

_____

_____

Include details of above, and additional information about the camper you would like us to know (attach additional information if needed). The camp staff may contact you for more information. _____

_____

_____

_____

_____

Medical Providers

Name of camper physician: _____ Phone: _____

Name of camper dentist/orthodontist: _____ Phone: _____

Camper Health Insurance Provider: _____ Policyholder: _____ Phone: _____

*** Restrictions may apply to camp insurance. Camp insurance does not cover pre-existing conditions.**
FULL REFUNDS through April 15. See refund policy for full details at *fw.ky.gov*.

PLEASE COMPLETE THIS FORM AND MAIL AS SOON AS POSSIBLE TO:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp. I hereby give permission for my child to be administered prescription and non-prescription medication as needed unless otherwise noted. I also hereby give permission for pictures to be taken of my child during camp and I understand that they may be used for future promotional purposes. I hereby certify that all information provided herein is true, accurate and complete. If I have failed to provide or have withheld information or have provided inaccurate responses, I understand that the application will be rejected and any deposit will not be returned.

Signature of Parent or Guardian _____

Print Parent or Guardian Name _____ **Date** _____