

SUMMER FUN FOR 7TH-8TH GRADE KENTUCKY STUDENTS



# VENTURE CAMP

*Camp Webb*

**AUGUST 4-8, 2014**

APPLY BEFORE APRIL 15

*Limited spots  
available*

**COST: \$230** →

**Activities:**

INCLUDES TRANSPORTATION, CAMPER INSURANCE  
AND JUNIOR SPORTSMAN'S LICENSE

*Animal Tracking*

*Boating Trip*

*Explore Bowhunting*

*Intro to Bowfishing*

*Night Fishing*

*Swimming*

*Range Day: rifle,*

*shotgun, crossbow*



FOR MORE INFORMATION VISIT

**FW.KY.GOV**

or call 1-800-858-1549

# CAMP ROBERT C. WEBB

## 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: \_\_\_\_\_  M  F SSN: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Parent phone numbers: \_\_\_\_\_

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: \_\_\_\_\_  
Medicine: \_\_\_\_\_  
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 [fv.ky.gov](http://fv.ky.gov).



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

Jack Lee  
101 Adams Ridge  
Hazard, KY 41701

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 \_\_\_\_\_