



June 9 - June 14, 2008

CAMPER APPLICATION For Parents to Complete

Last Name: _____ First Name: _____ Nickname: _____

Child's Age: _____ Birth Date: _____ Grade in School: _____

Home Address: _____ Street: _____

City: _____ State: _____ Zip Code: _____

Who does your child live with? _____ Relationship to Child: _____

Parent's Name: _____

Parent's Contact Info:

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Emergency Contact:

Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Has your child been a Camp Rainbow camper before? YES NO If Yes, when: _____

What diagnosis qualifies your child for Camp Rainbow? _____

When was your child diagnosed? _____

Who is your child's Medical doctor? _____

Doctor's Address: _____ Street: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____

What does your child know or understand about his/her illness? _____

Please list your child's: Weight _____ Height _____ Shirt Size: _____ Child Sz Adult Sz

Does your child use: Wheel Chair Walker Crutches Braces Prosthetic Limb

Please explain any assistance that is needed for your child to walk or be ambulatory: _____

Does your child need any unusual assistance with personal care needs? _____

Has your child stayed away from home before? _____

Does your child have any problems communicating with others? _____

**** If your child has Cystic Fibrosis, he/she will need cultures (Please See Medical Form)****

Please answer YES or NO to the questions below: (Please make extra comments as needed) We want to know as much about your child as possible.

Are there any physical conditions to prevent your child from being in the swimming pool? Yes No

Any problems being in the sun or heat with proper precautions? Yes No

Are there any hearing or vision impairments? Yes No

Has your child had Chicken Pox? Yes No Date of Disease or Vaccine: _____

Does Camp Rainbow have permission to do the following:

Let your child ride horses with assistance? Yes No

Ride on a hay ride? Yes No

Ride in a boat? Yes No

Get a haircut from a professional hair stylist? Yes No

Ride on a motorcycle on Camp grounds with a biker? Yes No

Ride in a car if needing to leave the Camp grounds for some reason? Yes No

Have a photo taken at Camp? Yes No

Be included on brochures, pictures, or television if chosen to do so? Yes No

Camp Pick-Up Day is Saturday, June 16 at 9:00 am. Who will pick up your child from Camp? _____

I/We _____ the parent(s) of _____ agree for our child to attend the functions provided by Camp Rainbow from June 9 to June 14, 2008. I/We release Camp Rainbow and its volunteers from any and all liability to my/our child as a result of transportation to and from the aforementioned Camp; engagement of activities during Camp; use of materials, buildings, and/or environment; and specifically give my permission for my/our child to attend this function.

Signature: _____

Date: _____

This form along with the Medical form should be sent to us by May 1, 2008 To

**By Mail: Camp Rainbow
PO Box 3522
Clarksville TN 37043**

By Fax: 931 245-7069

By E-mail: dreamfactory@bellsouth.net

Questions can be directed to:

Diane Miner, Camp Co-Director Hm# 931 648-4821 OR Wk# 931 245-7000



June 9 - June 14, 2008

MEDICAL APPLICATION For Child's Doctor to Complete

Parents Complete This Section Only

Last Name: _____ First Name: _____ Date of Birth: _____

Child's Medical Doctor: _____

Diagnosis that qualifies your child for Camp Rainbow: _____

Any known allergies to medications (Please List): _____

Medication given to your child at home (Attach a separate sheet if needed)

Medication Name	Amount Given	How Often

By sending this form, I give my permission to release medical information to the Camp Rainbow staff and physician. I also understand this medical information will be reviewed with my child's assigned Camp Rainbow counselor(s) for this year's camp session.

Signature: _____ Date: _____

Physician's Office - Please Complete This Section

Physician's Name: _____

Practice Name: _____

Physician's Address: Street: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____

Office Fax: _____

After Hours Contact Numbers: _____

Date of child's last exam or office visit: _____

Child's diagnosis and original date of diagnosis (Please indicate if in remission): _____

**** With this application, children with Cystic Fibrosis must provide sputum culture proof of no multiple drug resistant pseudomonas****

Culture Done: _____ n/a: _____

Other diagnosis, not related to primary diagnosis: _____

Other helpful information: _____

Please list medications the child should take while at Camp during the week of June 9 - June 14, 2008

Medication Name	Dosage	Administration Schedule

Is the child allergic to any medications: Yes No

If **Yes**, please list: _____

Any Latex allergies? _____

Has the child had Chicken Pox? _____

Any treatments or surgeries prior to Camp? _____

Any diet restrictions while at Camp? _____

Any lab work required while the child is at Camp? _____

Immunization Record: (Please attach a copy of an existing record OR complete the section below)

DTaP/Hep B/IPV	#: _____	Date: _____	Polio	#: _____	Date: _____
Hepatitis B	#: _____	Date: _____	Pneum Conj (PCV)	#: _____	Date: _____
DtaP/DT/Td	#: _____	Date: _____	MMR	#: _____	Date: _____
DtaP/Hib	#: _____	Date: _____	Varicella	#: _____	Date: _____
Td Booster	#: _____	Date: _____	Hepatitis A	#: _____	Date: _____
Hib	#: _____	Date: _____	Meningococcal	#: _____	Date: _____
Hib/Hep B	#: _____	Date: _____			

The enclosed information status on the above named child is accurate according to the best available information on file.

Signature: _____ Date: _____

Please return this Medical Form to us by May 1, 2008.

By Mail: Camp Rainbow **By Fax:** 931 245-7069 **By E-mail:** dreamfactory@bellsouth.net
 PO Box 3522
 Clarksville TN 37043

Questions can be directed to:
 Bird Petersen or Diane Miner, at Premier Medical Group, 931 245-7000