



*Animal Exploration Kids Summer Camp
Bridges for Brain Injury, Inc
5297 Parkside Drive, Suite 307
Canandaigua, NY 14424
(585) 396-0070*

Childs Last Name: _____ Childs First Name: _____

- Boy T-shirt Size: Child-Small, Medium, Large
 Girl Adult- Small, Medium, Large, X-Large, XX-Large

Date of Birth: _____ Age at camp: _____ Attended Day camp previously: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Cell Phone: () _____

Parent/Guardian one: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone :() _____

Work Phone :() _____ Cell Phone :() _____

Parent/Guardian two: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone :() _____

Work Phone :() _____ Cell Phone :() _____

Emergency contact 1: _____ Contact Number :() _____

Emergency contact 2: _____ Contact Number :() _____

Primary Physician: _____ Phone Number: () _____

Insurance Provider: _____ Plan Number: _____

Policy Holders Name: _____

Photo Release: I give Bridges for Brain Injury Inc. / Wildlife Defenders program permission to use any photos taken of my child at camp for promotional materials and use on the agency website:

Acknowledgement: I acknowledge that I have read and understand the camp policies and will adhere to them as written:

Signature of Parent/Guardian: _____ Date: _____

Notice: Day Camp fees may qualify for child care tax credit. Consult your Tax Professional.

Camper Medical History

(This form is mandated by the NYS Department of Health. Parents must fill out this section completely and submit at the time of application.)

Child's Name: _____ Birth date: _____ Weight: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone :() _____ Alternate Phone: () _____

My child may be released to the following persons:

1. Name: _____ Phone :() _____ Relationship: _____
2. Name: _____ Phone :() _____ Relationship: _____

In case of emergency the following person(s) should be notified:

1. Name: _____ Phone :() _____ Relationship: _____
2. Name: _____ Phone :() _____ Relationship: _____

If the camp is unable or does not have the time to locate the person(s) designated to be notified in the event of an emergency, I hereby give permission to take emergency measures as they deem appropriate for the welfare of my child while at camp.

Signature of parent/Guardian: _____ Date: _____

Does your child have any of the following illness? Please include any other information you feel will be helpful in the comments section.

- Recurrent ear infections
- Heart disease/defect
- Physical disability or handicap
- Asthma or bronchitis
- Epilepsy or convulsions
- Diabetes
- Allergic reaction to insect bites, medication, food, etc:
 - Please list: _____
- Other/comments: _____

This section must be filled out by your family physician or healthcare provider:

Does the camper require medications while they are at camp?

Please list below:

Medication _____ Dose time _____
Medication _____ Dose time _____
Medication _____ Dose time _____
Medication _____ Dose time _____

*** All medications must be in original dosing container ***

Each camper is required to have a health examination within 24 months of camp attendance, as evidenced by a form signed by a licensed physician. I have examined the above camp applicant within the past two years. In addition, the medical history and the immunization records have been reviewed.

In my opinion, the above's condition:

- Does
- Does not preclude his/her participation in an active camp program.

Recommendations/restrictions while at camp: _____

Licensed Physician signature: _____ Date: _____

Date of health exam: _____ Date form completed: _____

*** Please attach a copy of the child's current vaccination schedule***