

APPLICATION
2018 DEAF DAY CAMP (June 11-15)
(Ages 5-12 Years)
There Is No Charge For This Camp

Date Application Made: _____ Child Is: (circle one) Deaf Hard-of-hearing Hearing

Name of Child: _____ Birth Date: _____ Age: _____

Address: _____ / _____ / _____ Telephone: _____
Street/Post Office Box City Zip

Parents' or Guardians' Names: _____ / _____
Father Mother

Parents' or Guardians' Email: _____

In case of an emergency, contact:

Name: _____ Relation to Child: _____

Address: _____ / _____ / _____ Telephone: _____
Street City Zip

Person to contact if this person cannot be notified:

Name: _____ Relation to Child: _____

Address: _____ / _____ / _____ Telephone: _____
Street City Zip

Please answer the following questions:

Is your child on any type medication which is to be given each day? (circle one) Yes or No

If yes, name medication: _____

Directions for taking medication: _____

Is there any food that your child should not have? (circle one) Yes or No

If yes, name food: _____

Does your child have any allergies? (circle one) Yes or No

If yes, name them: _____

Is there any reason that your child cannot do physical activities such

as swimming, bowling and outdoor activities: (circle one) Yes or No

If yes, please explain: _____

Is your child toilet trained? (circle one) Yes or No

Name any other needs your child may have: _____

List some of your child's favorite activities: _____
