

We want your camper’s experience at “RAINBOW SPIRIT a camp for kids” to be the best it can be. Please help us by answering the following questions thoroughly:

Has your child ever been to camp before? Yes No Name of Camp and length: _____

Are your child’s friends typically: older younger same age?

Does your child have a basic understanding of his or her parent’s sexual orientation (lesbian, gay, bisexual, transgender)? Yes No Comments: _____

In the past year, have there been any significant changes in family relationships or home life (move, death, separation, new family member) we should know about? Yes No Comments: _____

Does your child have any special needs we should know about (home sickness, bedwetting, anger control, school related difficulties)? Yes No Comments: _____

Does your child have any food dislikes? (do not include allergies) Yes No Comments: _____

CONFIDENTIALITY AND PHOTO PERMISSION

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- I give my permission for my child during to be included in large or small group photos to be sent to my child and other children attending camp.
- I give my permission for photos of my child to be used for publicity purposes in the future.
- I do not give my permission for photos to be taken of my child while at camp.
- I wish to be contacted to discuss this matter further.

Signature of Parent or Guardian Completing this Form

Date

CAMPER'S HEALTH AND PERMISSION FORM

Please note: If your child takes prescription medication (other than BC pills), an additional form must be completed by your physician to allow us to administer prescription medications to your child at camp. This form is available on our website to download and to send to your physician. If you do not have web access call 455-0186 for the form. All medications, including over the counter medications, except for puffers and anaphylaxis kits will be kept in a locked cabinet.

CAMPER NAME: _____ **HEALTH CARD #:** _____

IN CASE OF EMERGENCY, IF PARENTS CANNOT BE REACHED, PLEASE NOTIFY:

NAME: _____ PHONE (Home): _____ (work): _____

ADDRESS: _____

DOCTOR'S Name: _____ **PHONE:** _____

DOCTOR'S Address: _____

Does your child have a recent history of any of the following?

- | | | | | |
|--|---|--|--|-----------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Speech impairment | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Home Sickness | <input type="checkbox"/> Asthma |

Please indicate the symptoms and treatments required for the above conditions:

Describe any other health problems you child has and any medical treatment required:

Does your child have any food allergies, sensitivities or food special needs? YES NO

If yes, please specify: _____

Please describe reaction and treatment: _____

Does your child have any drug allergies or sensitivities? YES NO

If yes, please specify: (include over the counter drugs/ointments such as benadryl, gravol, antibiotic ointment): _____

Please describe reaction and treatment: _____

Does your child have any other allergies or sensitivities? YES NO

If yes, please specify: (include bee stings, latex, asthma/allergen triggers such as dust, pollen, animal dander, physical exertion):

Please describe reaction and treatment: _____

I am unaware of any allergies my child may have. However, if any reaction should arise during camp, please treat as deemed necessary by camp nurse / doctor or trained first aider: YES NO

Is your child on any regular medication? YES NO Specify: _____

If yes, please specify whether your child will need medication at camp? YES NO

(Please note: If prescription medication is required (other than BC pills), an additional form must be completed by your physician in order for us to administer prescription medications to your child – see note above).

Has your child been exposed to any communicable disease in the 3 months prior to camp? YES NO

Please describe: _____

If your child is exposed to a communicable disease after completing this form, please contact us before camp.

How would you rate your child's swimming ability? Non-swimmer Fair Good Excellent

Can your child swim 25 metres? YES NO

Swimming level obtained, if any? _____

Is there any activity in which your child should not participate? YES NO

Please explain: (include any serious fears of child) _____

I give permission for sun screen and /or insect repellent to be applied to my child. YES NO

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If yes, please specify: _____

Please describe reaction and treatment: _____

Does your child have any drug allergies or sensitivities? YES NO

If yes, please specify: (include over the counter drugs/ointments such as benadryl, gravol, antibiotic ointment): _____

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Is your child on any regular medication? YES NO Specify: _____

If yes, please specify whether your child will need medication at camp? YES NO

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Please describe: _____

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How would you rate your child's swimming ability? Non-swimmer Fair Good Excellent

Can your child swim 25 metres? YES NO

Swimming level obtained, if any? _____

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Signature of Parent or Guardian

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FAMILY PRIDE CAMPING ASSOCIATION
Suite 121-3045 Robie Street
Halifax, Nova Scotia B3K 4P6
Phone: 455-0186
E-Mail: info@fpca.ca Website: www.fpca.ca



CAMPER REGISTRATION FORM

Please complete a separate form for each camper and return to Family Pride Camping Association at the above address. **DEADLINE FOR REGISTRATION IS JUNE 8, 2004.**

CAMPER NAME: _____ **Gender:** Female Male **Age at Camp:** _____

Birth Date: (Month/Day/Year) _____ **School Grade Completed June 2004:** _____

PARENT / GUARDIAN NAMES: _____

Home Address: _____
(street) (city) (province) (postal code)

Mailing Address (if different): _____

Phone: (home): _____ (work): _____ (other): _____

E Mail: (Parent): _____ (Child): _____

Address of Other Parent(s): (if different from child's) _____

Name of Parent to whom communication should be directed: _____

Information will be sent to more than one address/parent upon request.

I am registering my child for:
 Junior Leadership Camp – July 2 to 10, 2004
 Children's Camp – July 4 to 10, 2004
 Counsellor in Training Camp – July 2 to 10, 2004

Junior Leaders and Counsellors in Training (CITs) will receive leadership training from July 2-4 and will attend the Children's Camp. CITs will also be expected to attend staff training sessions scheduled in May/June 2004.

I am enclosing the fee for:

<input type="radio"/> Junior Leadership Camp	<input type="radio"/> \$225.00 (if paid after May 8, 2004)
	<input type="radio"/> \$205.00 (early bird – pay by May 8, 2004)
<input type="radio"/> Children's Camp	<input type="radio"/> \$285.00 (if paid after May 8, 2004)
	<input type="radio"/> \$265.00 (early bird – pay by May 8, 2004)
<input type="radio"/> Counsellor In Training	<input type="radio"/> \$50.00

Please make cheques or money orders payable to: **Family Pride Camping Association** and return with form.

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If yes, please specify: _____

Please describe reaction and treatment: _____

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- | | | | | |
|--|---|--|--|-----------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Speech impairment | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Home Sickness | <input type="checkbox"/> Asthma |

Please indicate the symptoms and treatments required for the above conditions:

Describe any other health problems you child has and any medical treatment required:

Does your child have any food allergies, sensitivities or food special needs? YES NO

If yes, please specify: _____

Please describe reaction and treatment: _____

Does your child have any drug allergies or sensitivities? YES NO

If yes, please specify: (include over the counter drugs/ointments such as benadryl, gravol, antibiotic ointment): _____

Please describe reaction and treatment: _____

Does your child have any other allergies or sensitivities? YES NO

If yes, please specify: (include bee stings, latex, asthma/allergen triggers such as dust, pollen, animal dander, physical exertion):

Please describe reaction and treatment: _____

I am unaware of any allergies my child may have. However, if any reaction should arise during camp, please treat as deemed necessary by camp nurse / doctor or trained first aider: YES NO

Is your child on any regular medication? YES NO Specify: _____

If yes, please specify whether your child will need medication at camp? YES NO

(Please note: If prescription medication is required (other than BC pills), an additional form must be completed by your physician in order for us to administer prescription medications to your child – see note above).

Has your child been exposed to any communicable disease in the 3 months prior to camp? YES NO

Please describe: _____

If your child is exposed to a communicable disease after completing this form, please contact us before camp.

How would you rate your child's swimming ability? Non-swimmer Fair Good Excellent

Can your child swim 25 metres? YES NO

Swimming level obtained, if any? _____

Is there any activity in which your child should not participate? YES NO

Please explain: (include any serious fears of child) _____

I give permission for sun screen and /or insect repellent to be applied to my child. YES NO

AUTHORIZATION AND RELEASE

I hereby declare that all of the information provided is correct and accurate to the best of my knowledge. I give permission for my child to participate in "RAINBOW SPIRIT a camp for kids" sponsored by the Family Pride Camping Association. I recognize that although safety will be considered of utmost importance, outdoor activity by its nature, involves elements of risk. I acknowledge that my child may be involved in outdoor activities that involve elements of risk, such as hiking, canoeing, kayaking, swimming, games and low ropes. In the event I cannot be reached in an **emergency**, I hereby give permission to the physician selected by the Camp Director or designate to hospitalize, secure proper treatment, and to order injection, anaesthesia or surgery for my child.

I hereby release the Family Pride Camping Association, its officers, directors, staff, volunteers and agents from any liability whatsoever in respect of any personal injury, death, property loss or other damages which I or my child may suffer through attendance at "RAINBOW SPIRIT a camp for kids". I do hereby waive my rights to make any claims or bring any causes of action against the Family Pride Camping Association, its officers, directors, staff, volunteers and agents. I have read the above in its entirety and sign below freely and voluntarily.

Signature of Parent or Guardian

Date