

# APPLICATION for **CAMP BEAVER LAKE** or **PRATT'S FALLS NATURE CAMP**

Circle Session **A B C D E F G H I J K L M N O P Q R S**

**PRE-CAMP SUPERVISION** 8 a.m.- 9 a.m. (*circle requested days*) **Mon Tues Wed Thurs Fri**

**POST-CAMP SUPERVISION** 3 p.m.- 5 p.m. (*circle requested days*) **Mon Tues Wed Thurs Fri**

**PARENTS: Thank you for sending your child to camp! please read the following...**

Complete application, sign, and return payment to **Beaver Lake Nature Center, 8477 East Mud Lake Rd, Baldwinsville, NY 13027**. If you have questions, please call Beaver Lake at: **(315) 638-2519**.

If you join the **Friends of Beaver Lake** or renew membership, please make checks and payments to the **Friends of Beaver Lake**, Thank you!

**Parental Authorization:** The NYS Health Department requires an original signature of parent/guardian. They require a complete immunization record; it may be completed by parents or **faxed** by the physician to Beaver Lake at: **(315) 638-7488**.

Physician Authorization is not required your child has had a serious illness or surgery within the last year.

Pre-Post Care is available from 8 a.m. - 9 a.m. and 3 p.m. - 5 p.m. for **\$2 per hour**. Please let us know in advance.

Confirmation and further information will be mailed as camp approaches.

Checks may be made out to **Beaver Lake Nature Center** for both Camp Beaver Lake and Pratt's Falls Camp.

MasterCard /Visa are accepted, payment will reserve space: *Please send application at least one week before camp (thanks).*

Refunds given until one week prior to session. **\$25.00 non-refundable administration fee applies to all cancellations.**

**We look forward to seeing you at our CAMP!**

<b>Camper's name:</b>	DOB:	Age	M / F	Grade completed	T-shirt size
Address:	City		State		Zip

<b>Parent/Guardian</b>			
e-mail (optional):			
Address:	City	State	Zip
Phone (h)	(w)	cell	

<b>Emergency Contact: (if parent/guardian cannot be reached)</b>			
Address:	City	State	Zip
Phone (h)	(w)	cell	

<b>Physician:</b>	Phone:		
Address:	City	St	Zip

## MEDICAL INSURANCE INFORMATION:

Insurance Company:	ID#:
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## IMMUNIZATION HISTORY *fill in date*

DPT Series	Booster	Tetanus booster
Polio OPV (Sabin)	Booster	Mumps Vaccine (live)
Measles Vaccine (live)	German Measles (rubella)	Other

## HEALTH HISTORY *Please check any that apply and approximate date*

Hay Fever	Asthma	Heart Murmur
Poison Ivy	Chicken Pox	Diabetes
Insect stings	Measles	Convulsions
Penicillin	German Measles	Fainting
Other drugs	Mumps	Chronic/Recurring Illness
Foods	Hepatitis	Operations
Other Allergies	Rheumatic Fever	Serious Injuries

**List Medication(s)** taken regularly (medicine brought to camp will be held safely by Camp Health director)

Is camper under medical care for any reason	YES	NO
If yes, please explain:		

## Physician Authorization *(if required)* This child is physically able to participate in day camp activities

Signature	Date
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## PARENTAL AUTHORIZATION:

Camper has permission to participate in all activities. Camp Director is authorized to act for the best interest of my child.

Signature	Date
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