Application Worksheet
Rosecrance McHenry County Summer Camp

Name: (first)_____ (last)_____
DOB: _____/_____/_____ Age:_____ Weight:_____lbs
Responsible Adult Name: (first)_____ (last)_____
Primary Phone#: (___)-___-_____ (home) (cell) (office)
Secondary Phone#: (___)-___-_____ (home) (cell) (office)
Email:_____
Home Address:_____ City:_____ Zip:_____
_____
Emergency Contact:_____ Relationship: _____
Primary Phone#: (___)-___-_____ (home) (cell) (office)
Secondary Phone#: (___)-___-_____ (home) (cell) (office)
Email:_____
Family Physician:_____ Phone #:_____
Insurance Carrier:_____ Policy #:_____ Group #:_____
Currently a Rosecrance McHenry County Client? (Yes) (No)

General Information (Check all that apply)	**Yes**	**No**
Asthma:		
Diabetes:		
Hemophilia:		
High Blood Pressure:		
Kidney Disease:		
Cancer/Leukemia:		
Allergies:		
Food_____		
Medicine_____		
Plants_____		
Insects_____		
Other_____ _____		

Please list ALL medications taken on a regular basis
_____
_____
List any medications to be taken during camp:_____
_____

Name	Dose	Route	Frequency

List any physical or behavioral conditions that may limit Full participation in strenuous physical activities:_____
_____

Immunizations: (Give year of last inoculation.)
Tetanus toxoid_____Measles_____Polio_____
Hepatitis A_____Chicken Pox_____

I give permission for full participation in Summer Camp, subject to limitations noted herein.
In case of emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the licensed/certified practitioner in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child.

Date:___/__/_____Signature of parent/guardian: _____

Family Day:

Do you plan on attending the awards celebration on Friday from 3-4pm? Yes No

For Non-Medicaid Clients seeking Reimbursement:

Following camp, I would like to be provided a list of services performed that I may be able to pursue reimbursement for.

Yes No Date:___/__/_____Signature of parent/guardian: _____

I understand that all fees must be paid prior to the camp.

Yes No Date:___/__/_____Signature of parent/guardian: _____

Attendance Policy:

I understand that by completing this application I am agreeing to attend the entire weeks sessions and/or at a minimum three full days. As this camp has a limited number of openings I understand that I will provide notification no fewer than 5 days before the onset of camp of my child's inability to attend.

My child will attend the following FULL WEEEK MON TUES WED THURS FRI

Date:___/__/_____Signature of parent/guardian: _____

Prospective Clients Not Currently Enrolled:

I agree to provide the necessary documentation required to verify appropriateness and open a client file for the week of the camp. I understand that all records will be kept confidential in accordance with the Rosecrance client confidentiality policy.

Date:___/__/_____Signature of parent/guardian: _____

Camp Types:

Please select the summer camp(s) you are applying for:

_____ Adventureland Camp (June 9 – 13)

_____ Amazing Race Camp (July 7 – 11)

_____ Imaginarium Camp (August 11 – 15)