



### Summer 2018 Application

Camper's Name \_\_\_\_\_ Nickname \_\_\_\_\_

M or F \_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Current Grade \_\_\_ School \_\_\_\_\_

Home Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_ Primary Email Address \_\_\_\_\_

### Sessions Attending

- |  |                                |                                  |
|--|--------------------------------|----------------------------------|
| <b>Camp Session 1</b> <input type="checkbox"/> | <b>\$450 per Session</b>       | <b>T-Shirt Size</b>              |
| <b>Camp Session 2</b> <input type="checkbox"/> |                                | <b>(circle one)</b>              |
| <b>Camp Session 3</b> <input type="checkbox"/> |                                | <b>XS S M L XL</b>               |
| <b>Camp Session 4</b> <input type="checkbox"/> | <b>\$40 per Saturday Night</b> | <b>(S is = to a youth large)</b> |
| <b>Camp Session 5</b> <input type="checkbox"/> | <b>Inter-Session Fee</b>       |                                  |
| <b>Camp Session 6</b> <input type="checkbox"/> | <b>Includes Laundry</b>        |                                  |
| <b>Camp Session 7</b> <input type="checkbox"/> |                                |                                  |

Inter-Session: Campers attending back-to-back sessions may stay at camp between sessions from Check-Out on Saturday through Check-In on Sunday. Campers will be supervised and have camp to themselves for fun activities which may include swimming, games, arts and crafts, and movies with plenty of time for rest and relaxation.

Camp Store: Our camp store will be open daily after Siesta time. It will be stocked with healthy snacks, drinks, camp necessities (batteries, stationary, stamps, soap, shampoo, etc.) and Camp Berger gear (t-shirts, hats, lanyards, flashlights etc.). Suggestion \$25 per week.

Parent/Guardian Primary Contact  
 Relation \_\_\_\_\_ Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_ Business Phone \_\_\_\_\_



Emergency Contact & Alternative Authorized pick up Person

Relation \_\_\_\_\_ Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Business Phone \_\_\_\_\_

What Did You Do Last Summer? \_\_\_\_\_

Previous Camps Attended? \_\_\_\_\_

How Did You Hear About Camp Berger? \_\_\_\_\_

\_\_\_\_\_

To reserve a space for camp a deposit of \$100 per session must accompany this application.

Remaining balance due June 1<sup>st</sup>

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Amount Due:

Number of Sessions	_____ x \$450 =	_____	_____
Number of Saturday Inter-Sessions	_____ x \$40 =	_____	+ _____
Camp Store Money	Sessions x Weekly Amount =	_____	+ _____
Deposit: Sessions x \$100 Due with this Application	=	_____	- _____
Balance Due less Deposit	Amount Due by June 1 <sup>st</sup> =	_____	_____



## Camper Questionnaire

Camper name \_\_\_\_\_

**Swimming experience (circle one):**    Non Swimmer            Beginning Swimmer            Competent Swimmer

Lake Experience    YES  NO             River Experience    YES  NO

**Is there a history of:**

- |   |   |   |
|---|---|---|
| Asthma/Respiratory: YES <input type="checkbox"/> NO <input type="checkbox"/>  | Sleep Disorders: YES <input type="checkbox"/> NO <input type="checkbox"/>   | Sinus issues: YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| Ear infections: YES <input type="checkbox"/> NO <input type="checkbox"/>      | Head injury: YES <input type="checkbox"/> NO <input type="checkbox"/>       | Headaches: YES <input type="checkbox"/> NO <input type="checkbox"/>         |
| Stomach issues: YES <input type="checkbox"/> NO <input type="checkbox"/>      | Heart problems: YES <input type="checkbox"/> NO <input type="checkbox"/>    | Seizures/Epilepsy: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Sleep-walking: YES <input type="checkbox"/> NO <input type="checkbox"/>       | Behavioral issues: YES <input type="checkbox"/> NO <input type="checkbox"/> | Food Allergies: YES <input type="checkbox"/> NO <input type="checkbox"/>    |
| Allergies: YES <input type="checkbox"/> NO <input type="checkbox"/>           | Physical Problems: YES <input type="checkbox"/> NO <input type="checkbox"/> | Bed Wetting: YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| Depression: YES <input type="checkbox"/> NO <input type="checkbox"/>          | Menstrual Issues: YES <input type="checkbox"/> NO <input type="checkbox"/>  | Eating disorder: YES <input type="checkbox"/> NO <input type="checkbox"/>   |
| Nervousness/Anxiety: YES <input type="checkbox"/> NO <input type="checkbox"/> | Skin/Sun issues: YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |

Please explain any of the above "yes" answers:

Special Dietary Needs Such As Vegetarian, Gluten-free, Lactose Intolerant or Other:

List any medical problem being currently treated:

Any other conditions being treated:

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_