

Camp Promise Application Form

Complete and return to:
501 McCaffery Rd, Bigfork, MT 59911
(Must be received by May 1st)

Office Use Only: Date Rec'd _____ Phys Rec'd _____ Amt Rec'd _____

Personal Information

Applicant's Full Name _____
Mailing Address _____
Sex _____ Age _____ Date of Birth _____ Phone Number _____
E-Mail Address _____ Previous Camp Experience _____
Applying for: Day Camp Overnight Week 1 Overnight Week 2 Either Overnight Week

Spaces reserved on a first-come basis. See website or call for dates.

Legal Guardian's Name _____ Phone Number _____
Mailing Address _____
Employer _____ Work Phone Number _____
Relationship to Applicant _____ Cell Phone Number _____
Emergency Contact Name (**Other than legal guardian**) _____
Phone Number _____ Relationship to camper _____

Disability History and Condition

Medical Diagnosis _____

School Placement / Grade Level _____

Reading / Writing Skills _____

Daily Living Activities

Dressing (Describe any assistance needed) _____

Speech / Communication (Describe any assistance needed) _____

Eating (Describe any assistance needed) _____

Bathing / Grooming (Describe any assistance needed) _____

Daily Living Activities Continued

Toileting (Describe any assistance needed) _____

Swimming (Describe skills and any assistance needed) _____

Equipment (List any equipment used and assistance needed) _____

Walking (Describe any assistance needed) _____

Arm / Hand Use (Describe any assistance needed) _____

Vision (Describe any assistance needed) _____

Hearing (Describe any assistance needed) _____

Rest / Sleep (Describe any routines or assistance needed) _____

Top bunk allowed? _____ Side rail needed? _____

Socialization (List hobbies and describe peer relationship skills) _____

Behavior (List any potential behavior problems and describe what reinforcements are effective) _____

Health History

Physician Name: _____ Physician Phone: _____

All Immunizations are up to date: Yes No

Please mark the following illnesses which you have had or have been vaccinated for.

- | | | |
|--|--|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Heart Issues | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Measles, German Rubella |
| <input type="checkbox"/> Measles, Hard Rubella | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Other: _____ | |

Seizures (Frequency, duration, observable behavior, etc., if applicable) _____

Describe any recent illness, injury or surgery _____

For female applicants – Describe symptoms of menstruation and assistance needed, if applicable _____

General Allergies: (Please check all that apply)

- | | | |
|--|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Bee Stings |
| <input type="checkbox"/> Cat or Dog | <input type="checkbox"/> Grass | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Mold | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Other: _____ | |

Food Allergies: (Please check all that apply)

- | | | |
|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish or Shellfish |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Legumes | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Pork | <input type="checkbox"/> Soy | <input type="checkbox"/> Tree Nuts |
| <input type="checkbox"/> Other: _____ | | |

Notify Camp Promise immediately if applicant is exposed to any communicable disease during the three weeks preceding their camp stay. Only medications listed on the physician’s form or authorized by the camp physician will be administered at camp. All medications must be brought to camp in the original prescription bottle.

Parent Authorization (This page must be completed for camp attendance.)

* I grant Big Sky Bible Camp permission to use camp photographs and/or video of my child for camp promotion and publicity.

* I give permission and consent for my child to be transported in a vehicle and/or boat with the understanding that the vehicle/vessel will be driven by a trained and qualified Big Sky Bible Camp staff member for the purpose of some camp activities.

* I understand that Big Sky Bible Camp only carries secondary insurance for campers and that I will take primary responsibility for any charges occurring in the event that the camper named above should need any medical attention at any clinic, facility or hospital.

* The undersigned, intending to be bound hereby, realizing it is the camp's desire to give each camper a safe and beneficial stay, and realizing each camper is covered by

a reputable insurance plan, releases forever Big Sky Bible Camp and all individuals associated therewith, from any and all liability for any injury or damage (including all claims and liability for damage resulting from injuries received from bee or hornet stings and any other insect bites) which may be sustained by the undersigned and/or child of undersigned or property of the same at or in transit to or from any camp conducted activity or under the auspices of Big Sky Bible Camp.

* I hereby give permission for the release of pertinent medical information regarding my child to all appropriate Big Sky Bible Camp staff.

* IN CASE OF EMERGENCY, I hereby give permission to the medical staff selected by the camp to hospitalize, secure proper treatment for and to order injection or surgery for my child as named above.

Signature of Parent/Guardian _____ Date _____

Printed name of Parent/Guardian _____