Epilepsy Foundation of Mississippi

ALVIN P. FLANNES SUMMER CAMP APPLICATION

May 30 – June 3, 3017

Dear Alvin P. Flannes Camp Parents:

Enclosed please find the 2017 Alvin P. Flannes Camp application form. Camp details are:

Dates:	Tuesday, May 30 – Saturday, June 3, 2017
Location:	Timbercreek Campground, 8113 Morton Marathon Road Pulaski, Mississippi 39152
Registration Fee:	$25
Deadline Date:	May 12, 2017

A physical examination form must be completely filled out by your child's **primary care physician or neurologist. This form may be completed by your doctor based on a physical examination during the last twelve months**. **Your child must have medical insurance.**

All forms must be completed and returned to the Epilepsy Foundation of Mississippi office no later than May 12th, 2017. Applications can be emailed to ttownsend@epilepsy-ms.org.

Complete applications include:

- ☐ Alvin P. Flannes Camp Application
- ☐ Signed Release Form
- ☐ Medication Schedule
- ☐ Over the Counter Medication Permission
- ☐ Behavior Expectation Form
- ☐ Physician's Physical Exam Card

Each application will be reviewed to determine if we can accommodate your child's special needs. No child will be able to attend camp unless all applicable documentation is completed.

We hope you will consider this an opportunity to provide your child with a wonderful and enriching experience.

Sincerely,

Executive Director

ALVIN P. FLANNES CAMP APPLICATION FORM

To be completed by Parent or Guardian

Send application and registration fee to:
Epilepsy Foundation of Mississippi
2001 Airport Road North Ste 307
Flowood, MS. 39232
Deadline to return application is May 12st, 2017

Please Type or Print: Date:______________________________

Camper Name ______________________________
Home Address ______________________________
City, State Zip Code
Home Phone Cell Phone ______________________________
Email Address ______________________________
Date of Birth: ______________ Age: ________ Gender: ☐ Female ☐ Male
Child Lives With: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: ______________________
Ethnicity: ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic ☐ White/Caucasian ☐ Other

This information is gathered for tracking purposes only and is not considered when making any determinations about financial assistance or camper attendance.

Mother or Guardian ______________________________
Address ______________________________
City, State ______________________ Zip Code ______________
Home Phone ______________________ Cell Phone ______________
Work Phone ______________________
E-Mail Address ______________________________
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Father or Guardian ______________________________
Address ______________________________
City, State ______________________ Zip Code ______________
Home Phone ______________________ Cell Phone ______________
Work Phone ______________________
E-Mail Address ______________________________
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Is there a Child Custody Order? ☐ Yes ☐ No Order Number ____________

List special resources utilized within the school setting? ☐ Yes ☐ No

Transportation is not provided by the Epilepsy Foundation of Mississippi and is the responsibility of the parent or guardian.

Primary Physician Office ____________

Physician Name ____________ Phone: ____________

Neurologist Office ____________

Neurologist Name ____________ Phone: ____________

Emergency Contact: ____________

Relationship to Camper: ____________ Phone: ____________

Who may pick up child other than parent? ____________

Your child must have medical insurance.

Medical Insurance Co. ____________

Policy #: ____________ I.D. # ____________

Name of Primary Insured ____________

Social Security # ____________

Employer Name ____________

Has the camper previously attended Alvin P. Flannes Camp? ☐ Yes ☐ No

Last year attended?

Aside from epilepsy, does your child have any other medical conditions (e.g. heart disease, lung disease, kidney disease, etc.)

Describe any previous experience with camping or outdoor activities your child may have?

Has the camper attended any other camp? ☐ Yes ☐ No

Camp Name ____________

SEIZURE/EPILEPSY INFORMATION:

Is epilepsy the camper's primary diagnosis? ☐ Yes ☐ No
If you checked no please explain:

Seizure Descriptions: Please tell us about your child's seizures.
Please complete this section completely. If not enough information is included, this can delay acceptance in Alvin P. Flannes Camp.

Seizure type 1:
☐ Staring ☐ Limb Jerking ☐ Full Body Convulsions ☐ Drop Attacks ☐ Other:___________

How often do these seizures occur? ☐ Once per day ☐ Multiple times per day
☐ Once per week ☐ Several Times Per Week ☐ Rarely ☐ Other:___________

When was the last time your child experienced this type of seizure?

____

What time of day do these seizures typically occur? ☐ Immediately upon awaking
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No particular pattern of time of day
☐ Other:___________

Loss of bladder or bowel control? ☐ Bladder ☐ Bowel ☐ Neither

What triggers these seizures? ☐ Lack of Sleep ☐ Overheating ☐ Flashing Lights
☐ Certain Foods, What: ____________ ☐ Other: ______________________________

Does your child display any warnings before these seizures? ? ☐ No ☐ Yes
If yes, what specifically:____

Do rescue medications need to be given? ☐ No ☐ Yes: Type: ______________________
Directions: ____

What happens after these seizures?
☐ Continues with daily activities ☐ Needs to rest for a few minutes ☐ Needs to sleep
☐ Other: ____

Seizure type 2:
☐ Staring ☐ Limb Jerking ☐ Full Body Convulsions ☐ Drop Attacks ☐ Other:___________

How often do these seizures occur? ☐ Once per day ☐ Multiple times per day
☐ Once per week ☐ Several Times Per Week ☐ Rarely ☐ Other:___________

When was the last time your child experienced this type of seizure?

____

What time of day do these seizures typically occur? ☐ Immediately upon awaking
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No particular pattern of time of day
☐ Other:___________

Loss of bladder or bowel control? ☐ Bladder ☐ Bowel ☐ Neither

What triggers these seizures? ☐ Lack of Sleep ☐ Overheating ☐ Flashing Lights
☐ Certain Foods, What: ______________ ☐ Other: ______________________________________

Does your child display any warnings before these seizures? ? ☐ No ☐ Yes
If yes, what specifically:____

Do rescue medications need to be given? ☐ No ☐ Yes: Type: __________________________
Directions: ____

What happens after these seizures?
☐ Continues with daily activities ☐ Needs to rest for a few minutes ☐ Needs to sleep
☐ Other: ____

Seizure type 3:
☐ Staring ☐ Limb Jerking ☐ Full Body Convulsions ☐ Drop Attacks ☐ Other:____________

How often do these seizures occur? ☐ Once per day ☐ Multiple times per day
☐ Once per week ☐ Several Times Per Week ☐ Rarely ☐ Other:____________

When was the last time your child experienced this type of seizure?

____

What time of day do these seizures typically occur? ☐ Immediately upon awaking
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No particular pattern of time of day
☐ Other:____________

Loss of bladder or bowel control? ☐ Bladder ☐ Bowel ☐ Neither

What triggers these seizures? ☐ Lack of Sleep ☐ Overheating ☐ Flashing Lights
☐ Certain Foods, What: ______________ ☐ Other: ______________________________________

Does your child display any warnings before these seizures? ? ☐ No ☐ Yes
If yes, what specifically:____

Do rescue medications need to be given? ☐ No ☐ Yes: Type: __________________________
Directions: ____

What happens after these seizures?
☐ Continues with daily activities ☐ Needs to rest for a few minutes ☐ Needs to sleep
☐ Other: ____

SAFETY PLANS:

1) Restrictions on Camp Participation: Please list all activities that your child may not participate in and any activities that may need special accommodations.

2) Adaptive or Safety Equipment: Please list any equipment or adaptive aids that your child uses to help him/her move around safely or prevent injury in other ways. Note when these aids should be used and other instructions for staff.

3) Other Safety Precautions: Please describe any other safety precautions that should be used for your child due to seizures or other health problems. Note if there are certain times that specific activities should be avoided and if alternative activities may be needed.

4) **Swimming & Boating: Does your child know how to swim?** ☐ Yes ☐ No

Does your child have your permission to be in the pool or lake with supervision? ☐ Yes ☐ No

____
Print Name of Parent/Guardian

____ ________________________
Signature of Parent/Guardian Date

GENERAL HEALTH QUESTIONS:

Your child is most like a child of what age? _________

Has/does the participant:	Yes	No
1. Had an recent injury, illness or infectious disease?.................................	☐	☐
2. Have a chronic or recurring illness/condition?..	☐	☐
3. Ever been hospitalized?..	☐	☐
4. Ever had surgery?..	☐	☐
5. Have frequent headaches?...	☐	☐
6. Ever had a head injury?...	☐	☐
7. Ever been knocked unconscious?..	☐	☐
8. Wear glasses, contacts, or protective eye wear?....................................	☐	☐
9. Ever had frequent ear infections?..	☐	☐
10. Ever passed out during or after exercise?...	☐	☐
11. Ever been dizzy during or after exercise?... .	☐	☐
12. Ever had chest pain during or after exercise?.......................................	☐	☐
13. Ever had high blood pressure?..	☐	☐
14. Ever been diagnosed with a heart murmur?..	☐	☐
15. Ever had back problems?...	☐	☐
16. Ever had problems with joints (e.g., knees, ankles)?............................	☐	☐
17. Have an orthodontic appliance being brought to camp?........................	☐	☐
18. Have any skin problems (e.g., itching, rash, acne)?.............................	☐	☐
19. Have diabetes?...	☐	☐
20. Have asthma?...	☐	☐
21. Had mononucleosis in the past 12 months?...	☐	☐
22. Had problems with diarrhea/constipation?..	☐	☐
23. Have any problems with sleepwalking?...	☐	☐
24. If female, have an abnormal menstrual history?.................................	☐	☐
25. Have a history of bed-wetting?..	☐	☐
26. Ever had an eating disorder?...	☐	☐
27. Ever had emotional difficulties for which professional help was sought?..	☐	☐

Please explain any “yes” answers, noting the number of the questions.

OTHER HEALTH CONCERNS: Include any problems that may affect his or her safety or ability to participate in camp activities.

Can your child tolerate high altitudes? ☐ Yes ☐ No
Does your child have difficulty with the summer heat? ☐ Yes ☐ No
Does your child wet themselves? ☐ Yes ☐ No
if so, please supply pull-ups and wipes
Does your child have a history of asthma? ☐ Yes ☐ No
Please consider having your pediatrician prescribe an albuterol inhaler as needed.
Does child have inhaler? ☐ Yes ☐ No
Allergies to medications, foods, etc.? ☐ Yes ☐ No
Please list any allergies:

Please include any notes on above answers:

EATING HABITS:

Regular Diet? ☐ Yes ☐ No Special Diet? ☐ Yes ☐ No
Needs Assistance? ☐ Yes ☐ No Food Allergies? ☐ Yes ☐ No

Dietary restrictions:

☐ Ketogenic Diet
☐ Celiac (Gluten allergy)
☐ Lactose (Dairy allergy)
☐ Does not eat poultry
☐ Does not eat pork
☐ Does not eat eggs
☐ Does not eat seafood
☐ Other: ______________________

Describe any special dietary needs/eating habits:

Alvin P. Flannes Camp can accommodate dietary restrictions for health and religious reasons only. **Please send meals and snacks that can be easily microwaved.**

OTHER CONCERNS: Please describe any problems that may affect your child in the following areas:

Does your child experience any of the following behaviors?
☐ Anxiety ☐ Panic ☐ Food Refusal ☐ Loner ☐ Other:________________________________

Mental Health/Behavioral Issues: Has your child has ever been diagnosed with a behavior or mood disorder or been given any other mental health diagnosis? ☐ Yes ☐ No
If so, please specify the diagnosis and what medications or other therapies your child is receiving or has received in the past five years for that condition.

Movement or ability to walk: Note if your child has problems with weakness, balance, coordination or other problems and if any mobility aides are used. Include any special accommodations to get around safely and tips for staff.

Senses: Note if your child has any problems with feeling (are they able to feel hot and cold, pain, etc.), vision, smelling, tasting or hearing. Include any special accommodations and tips for staff.

Communication: Note if your child has any difficulty speaking, understanding or writing. Include alternative methods of communicating that your child uses and any other special accommodations and tips for staff.

Social Skills: Note if your child has any problems with social skills or interacting with peers. Does your child make friends easily? **Does your child hit others?** Include any special accommodations your child may need or tips for staff.

Cognitive Impairments: Note if your child has any problems understanding instructions or rules.

Other concerns or problems:

ADDITIONAL INFORMATION: **Please complete the following information to better assist the camp staff to attend to your child's needs while at camp.**

Does your child possess any special skills or talents?

In what ways would you like camp to help your child develop?

Why is your child interested in attending camp?

Camper's primary interests and hobbies:

CHILD'S T-SHIRT SIZE:

☐ **YS** ☐ **YM** ☐ **YL** ☐ **AS** ☐ **AM** ☐ **AL** ☐ **AXL**

REFERRAL SOURCE:

How you hear about Alvin P. Flannes Camp?

☐ Returning Camper

☐ Previous Camper: ____________________

☐ Doctor's Name: _____________________

☐ Google or Yahoo Search

☐ Camp Directory: ____________________

☐ EFAZ Website

☐ EF National Website

☐ Other Website: _____________________

☐ Other: ______________________________

I verify that the above information is accurate and best represents my child's physical, emotional, and cognitive ability to participate in Alvin P. Flannes Camp.

____

Print Name of Parent/Guardian

____ ________________________

Signature of Parent/Guardian Date

Dates of immunization for:

Vaccine:	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*
DTP	______	______	______	______	______	______
TD (tetanus/diphtheria)	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Polio	______	______	______	______	______	
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus influenza B	______	______	______	______		
Hepatitis B	______	______	______			
Varicella (Chicken Pox)	______	______				

Dates of Last:

Diphtheria/Tetanus Booster: _______________________ Chest X-ray: _______________________

ALVIN P. FLANNES CAMP RELEASE OF CLAIMS AND CONSENT

(Page 1 of 2)

The parent or legal guardian of the camper attending Alvin P. Flannes Camp MUST sign the following consent agreement.

1. Alvin P. Flannes Camp/Epilepsy Foundation of Mississippi has my permission to use my child's image in print, on tape or film for any lawful purpose.

2. Alvin P. Flannes Camp/Epilepsy Foundation of Mississippi accepts no responsibility for the loss, damage or theft of my child's property.

3. Should any parent or guardian leave their place of residence while camp is in session, they must advise the camp administration where they can be contacted in case of emergency.

4. I understand that I am responsible for my child's Medical Insurance coverage while at Camp.

5. In case of medical and/or surgical emergency, I authorize the camp medical staff to render to my child or to arrange for my child to receive any x-rays, anesthesia, medical/dental/surgical procedure, treatment and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in the state of Mississippi.

6. You have my permission to talk to the school nurse about my child's condition
   School Name ____
   Name of Nurse _____________________________ Telephone_____________________

7. I acknowledge that camp activities have an inherent increased risk of injury. I assume full responsibility for my child's safety. I agree to release and indemnify Alvin P. Flannes Camp, the Epilepsy Foundation of Mississippi, the Epilepsy Foundation, and all of their agents, representatives and employees (Paid or Volunteer) from any claims, costs, expenses and/or damages which my child may sustain or incur.

8. I authorize a licensed professional to dispense any medications recommended or prescribed by a physician to my child.

9. I agree to hold the professional staff of Epilepsy Foundation of Mississippi, Epilepsy Foundation, and all their agents, representatives, employees and volunteers free from any liability which may arise from any accident or illness which may affect my child during his/her participation at Alvin P. Flannes Camp, May 30 – June 3, 2017.

____

Parent/Guardian Signature Date

RELEASE OF CLAIMS AND CONSENT - *Continued*

(Page 2 of 2)

10. Alvin P. Flannes Camp has my permission to transport ______________________________ in a private vehicle as required. (Camper's Name)

____

Parent/Guardian Signature Date

11. All of the above information is correct to the best of my knowledge. The child herein described has my permission to engage in all activities, except as noted by myself.

12. If my child experiences an unexpected medical or behavioral problem and the staff cannot handle the issue at camp, <u>you will be notified and agree that it is your responsibility to come to camp and pick up your child within 24 hours</u>.

Child's Legal Name: ____

____

Parent/Guardian Signature

____

Parent/Guardian Printed Narne

____

Date

ALVIN P. FLANNES CAMP MEDICATION SCHEDULE

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Medication must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Please provide a bill box for camp which can be found at any drugstore.

Name: ____

Date: ____________________

DIAGNOSIS (REASON FOR TAKING)	MEDICATION (FORMULATION)				
		AM (pills/sprinkles/mL) please circle	MIDDAY (pills/sprinkles/ mL) please circle	PM (pills/sprinkles/ mL) please circle	BEDTIME (pills/sprinkles/ mL) please circle
i.e.: Epilepsy	*Topamax (50mg tablets)*	*1*		*1*	

ALVIN P. FLANNES CAMP
OVER THE COUNTER MEDICATION PERMISSION FORM

I ______________________________, hereby give permission to the medical staff at Alvin P. Flannes Camp and Timber Creek Campground to administer the following over-the-counter medications to my child ______________________________, if the physician or nurse deem necessary. Dosages will be administered according to directions on the label unless otherwise directed by a physician.

Please initial next to any medications your child MAY NOT receive.

Initials	Complaint	Treatment
______________	Headache, Fever, Pain	Tylenol or Ibuprofen
______________	Abdominal Discomfort /Gas	Maalox
______________	Allergic Reaction	Benadryl
______________	Bug Bites	0.5% Hydrocortisone Cream, Benadryl
______________	Cold Sores	Blistex
______________	Constipation	Milk of Magnesia
______________	Cough; progressive	Cough Medicine
______________	Cough; non-progressive	Robitussin, Robitussin DM
______________	Cramps, Menstrual	Ibuprofen or Midol
______________	Head Lice	RID or Equivalent
______________	Muscle Aches	Ben Gay or analgesic ointment
______________	Poison Ivy, Oak, Sumac	Calamine lotion, 0.5-1% Hydrocortisone
______________	Ringworm	Lotrimin, Tinactin
______________	Soar Throat	Throat lozenges, Throat Spray
______________	Stuffy Nose	1% Neosynephrine Drops or Afrin Nasal Spray
______________	Motion Sickness	Dramamine
______________	Home Sickness	Melatonin

____ ______________________

Parent/Legal Guardian Signature **Date**

ALVIN P. FLANNES CAMP CAMPER BEHAVIOR EXPECTATION FORM

Timber Creek and the Epilepsy Foundation of Mississippi adhere to the highest safety standards and regulations set by the American Camping Association. Our goal at camp is to provide positive growth for all campers while in a safe, healthy, nurturing environment. To create and maintain such an environment will require the participation of staff and campers alike.

Please read the following information carefully so you and your child can fully understand and agree to the expectations set forth by Timber Creek and the Epilepsy Foundation of Mississippi.

Disciplinary Process

Most disciplinary situations at camp are minor and can be resolved with minimal corrections. Camp staff use discipline as a learning opportunity for the camper and try to integrate problem-solving skills into the discussion. However, if the negative behavior continues the following steps may be instituted.

1. Discussion between camper and counselor with set goals and objectives.
2. Discussion between camper, counselor, and Head Counselor to clarify goals and objectives previously set by the parties involved.
3. If the conduct continues, documentation of the negative behavior will be recorded in the form of a Behavior Contract signed by the camper, counselor, and Head Counselor. Program Coordinator will be made aware of the situation.
4. Program Coordinator will contact the parent/guardian to inform them of the situation and discuss possible options. Program Director will be made aware of the situation.
5. Program Director will contact parent/guardian to make arrangements for the campers' discharge from camp.

Although the above steps may be implemented, camp administrative staff retains the right to take immediate action if the campers' behavior poses a threat to their own safety, the safety of other campers or camp staff.

Cigarettes, Alcohol, Illegal drugs, Weapons and Sexually explicit material and/or behavior are grounds for immediate dismissal from camp.

I agree to the above stated expectations and understand that I will be responsible for any / all costs associated with the transport of my camper.

____ _______________

Parent/Guardian/Custodian **Date**

I ______________________________ agree to the above stated expectations.
(Camper Name)

____ _______________

Camper Signature **Date**

ALVIN P. FLANNES CAMP PHYSICAL EXAMINATION FORM

The following information must be completed by the child's neurologist or primary care physician for an examination made within 12 months of the camp dates. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Please provide complete information so that the camp can be aware of your child's needs.

Name: ______________________________________ **Date of Birth:** ____________________
School: ____ **Grade:** _____________
Address: _________________________ **City:** ________________ **State:** _____ **Zip:** ______
Date of Examination (*must be within 12 months of camp dates*)**:** _________________________

Height	_________	Weight	_________	Abdomen	_________	Skin	_________
Vision	_________	Corrected	_________	Curvature	_________	Feet	_________
Eyes	_________	Nose	_________	Posture	_________	Orthopedic	_________
Throat	_________	Tonsils	_________	Nervous Sys.	_________	Scoliosis	Neg ________
Ears	_________	Glands	_________	Urinalysis	_________		Pos ________
Lungs	_________	Heart	_________		Albumin	Nutrition	_________
BP	_________		_________		Sugar	Hemia	_________

Current Medications (in mg/dose): ____
____
____
____

The following are to prepare for adequate staffing at camp.
Does child have: ☐ Developmental Disabilities ☐ Learning Disabilities
☐ ADHD or Aggressive Behavioral Problems

Child behaves most like a child of what age? ______________________

Does child require assistance with activities of daily living? ☐ Yes ☐ No
If yes, how much?
____
____

Does child have any medical concerns other than epilepsy/seizures? ☐ Yes ☐ No

Operations:____
____

Fractures/Sprains/Dislocations:____
____

Allergies to Medications:____
____

Has child had:

Yes	No	Check each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
☐	☐	Allergy/Asthma/Eczema	☐	☐	Hepatitis A/B/C	☐	☐	Pneumonia
☐	☐	Anemia	☐	☐	Hives	☐	☐	Polio
☐	☐	Arthritis	☐	☐	Immune Deficiency	☐	☐	Rheumatic Fever
☐	☐	Chicken Pox	☐	☐	Kidney Problems	☐	☐	Sinus Trouble (Severe)
☐	☐	Concussion	☐	☐	Measles Reg./3 Day	☐	☐	Soar Throats (Chronic)
☐	☐	Diabetes	☐	☐	Menstrual Cramps (Severe)	☐	☐	Tuberculosis
☐	☐	Emotional Problems	☐	☐	Migraine Headaches	☐	☐	Valley Fever
☐	☐	Fainting (Frequent)	☐	☐	Mononucleosis	☐	☐	Whooping Cough
☐	☐	Heart Problems	☐	☐	Mumps	☐	☐	Other
☐	☐	Heat stroke/Exhaustion	☐	☐	Otitis (Ear Infection)			

Please explain any *yes* answers:

____

____

____

I hereby certify that I have, on this date, examined the above camper and I have found no medical reason to disqualify him/her from participating in all supervised camp activities and physical activities.

______________________ ____________________________________ __________

NAME OF PHYSICIAN SIGNATURE OF EXAMINING PHYSICIAN DATE

EMERGENCY CONTACT UPDATE FORM

We would like you to update this information in case we have to contact you during camp.
PLEASE BRING THIS FORM TO CAMP.

Please type or print: Date:________________________________

Camper Name ________________________________

Mother (Guardian) ________________________________
Address ________________________________
City, State ________________________________
Home Phone ________________ Zip Code ________________
E-mail ________________ Cell/Work Phone ________________
Father (Guardian) ________________________________
Address ________________________________
City, State ________________________________
Home Phone ________________ Zip Code ________________
E-mail ________________ Cell/Work Phone ________________

Is there a Child Custody Order? ☐ Yes ☐ No Order Number ________________

Emergency Contact: ________________________________
Relationship to Camper: ________________ Phone: ________________
Who may pick up child other than parent? ________________________________

If you have plans to be away during camp, where can we reach you?

Location ________________________________
Address ________________________________
City, State ________________________________
Phone ________________ Zip Code ________________
E-mail ________________ Cell/Work Phone ________________

These documents must be notarized by legal Notary of the state of Mississippi

Acknowledgment of Individual

STATE OF MISSISSIPPI

COUNTY OF _________________

Personally appeared before me, the undersigned authority in and for said county and state, on this __________ day of ____________________________, _________, within my jurisdiction, the within named _______________________________, who acknowledged that (he/she/they) executed the above and foregoing instrument.

____

Notary Public

Printed Name: _________________

My Commission Expires:

____