

# Martha's Vineyard Adventure Camp 2012 Registration Form

## Camper Information

Camper's Full Name: \_\_\_\_\_  
*First Last Nickname*

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age (as of June 25<sup>th</sup> 2012): \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Gender: Male Female

Can your child ride a bike? \_\_\_\_ Do they use gears? \_\_\_\_ Are you bringing your own bike? (Must be a MTN bike) \_\_\_\_

List anyone you would like your child to be grouped with: \_\_\_\_\_

## Parent Information

Parent/Guardian's Name: \_\_\_\_\_  
*First Last*

Address: \_\_\_\_\_  
*Street Address Apt/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Day Time Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

## Emergency Contact Information

*Contact #1*

Full Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
*First Last*

Relationship to Camper: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Contact #2*

Full Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
*First Last*

Relationship to Camper: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Insurance Information

Name of Health Insurance Provider: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Apt/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Policy Number: \_\_\_\_\_ ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Medical Information

Date of Last Physical Exam: \_\_\_\_\_ Last Known Tetanus Shot: \_\_\_\_\_ Known Allergies: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Over the Counter (OTC) Medicines camper has your permission to use: \_\_\_\_\_

Prescription Medicines camper has your permission to use: \_\_\_\_\_

## Martha's Vineyard Adventure Camp 2012 Registration Form

Sessions	Date	Cost	Discounts
<input type="checkbox"/> 1	June 25 – June 29	\$395	<div style="text-align: right; font-size: small;">*only one applies*</div> <input type="checkbox"/> 10% Early Bird Discount ( <i>Register before May 1, 2012</i> ) <input type="checkbox"/> 10% Multiple Camper or Session Discount <input type="checkbox"/> 20% Island Resident Discount
<input type="checkbox"/> 2	July 2 – July 6	\$395	
<input type="checkbox"/> 3	July 9 – July 13	\$395	
<input type="checkbox"/> 4	July 16 – July 20	\$395	
<input type="checkbox"/> 5	July 23 – July 27	\$395	
<input type="checkbox"/> 6	July 30 – August 3	\$395	
<input type="checkbox"/> 7	August 6 – August 10	\$395	
<input type="checkbox"/> 8	August 13 – August 17	\$395	
<input type="checkbox"/> 9	August 20 – August 24	\$395	
<input type="checkbox"/> 10	August 27 – August 31	\$395	
			Payment
			<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Check Card Number: Expiration Date ( <i>mm/yyyy</i> ): Credit Card Code ( <i>on back of card</i> ): Billing Address: City, State, Zip:

### Medical Emergency Authorization

I hereby authorize MARTHA'S VINEYARD ADVENTURE CAMP to arrange for emergency medical treatment for my child, while my child is under the Camp's care. I understand that in the event I cannot be reached, I hereby consent to and authorize the physician and hospital selected by the MARTHA'S VINEYARD ADVENTURE CAMP Supervisor to hospitalize, secure proper treatment for, to order injection, anesthesia, surgery and any preliminary, further and additional treatments, procedures, tests, etc., that may be in the judgment of the doctor and/or hospital advisable or necessary at the time, for my child, as named above. I hereby authorize the MARTHA'S VINEYARD ADVENTURE CAMP Director to administer over-the-counter medication (Tylenol, Dramamine, Pepto Bismol, etc.) and first aid for minor injuries as deemed necessary.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

### Liability Release

The parent/legal guardian agrees to hold harmless MARTHA'S VINEYARD ADVENTURE CAMP, LLC and all MVAC Personnel from any claims, damages, losses and/or expenses arising out of participation in camp activities and to assume all liability for any and all personal injury, bodily injury, illness or property damage that occurs as a result of participation in such camp activities. The parent/legal guardian also warrants that participation in this camp is voluntary and that the camper and the parent/legal guardian understand the inherent risks involved in camp activities, and the camper agrees to obey all rules and policies mandated by camp personnel.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Please email, fax or mail in your registration form to:**

*Martha's Vineyard Adventure Camp  
P.O. Box 4215  
Vineyard Haven, MA 02568  
Phone: (508) 693-8484  
Fax: (508) 693-0844  
info@mvadventurecamp.com*

# MARTHA'S VINEYARD ADVENTURE CAMP

## HEALTH HISTORY: Completed by Parent/Adult, Reviewed by Licensed Health Care Provider

1. Has the participant had any of the following (childhood) **diseases** or illnesses? Circle **no**, or give **approximate year** by **yes**:  
Chicken Pox **no** **yes**:\_\_\_\_\_ Measles **no** **yes**:\_\_\_\_\_ German Measles **no** **yes**:\_\_\_\_\_ Mumps **no** **yes**:\_\_\_\_\_
2. Any **serious illnesses or, major operations / medical treatments**? Circle answer (and if **yes** explain below) → **yes none**
3. Are the participant's **immunizations up to date**? If **no**, explain: \_\_\_\_\_, and circle answer → **no yes**
4. Has the participant had a **tetanus shot within ten years**? If **yes**, give date: \_\_\_\_\_ (**no** is permissible) circle → **no yes**
5. Any **current infectious diseases**? If **yes** explain: \_\_\_\_\_, and circle answer → **yes none**

*Please let us know if the participant is exposed to any infectious diseases after submitting this form and before camp starts.*

## HEALTH STATUS: Completed by Parent/Adult, Reviewed by Licensed Health Care Provider

6. Any **allergies or dietary restrictions** that we should know about? Circle answer (and if **yes** circle/list below) → **yes none**  
penicillin peanuts wheat/gluten beesstings hay animal fur Other: \_\_\_\_\_
7. Any **physical conditions** that may affect participation at camp? Circle answer (and if **yes** circle/list below) → → **yes none**  
asthma bed wetting hemophilia cancer lung disease nervous disorder orthopedic problem pregnancy  
epilepsy drug addiction alcoholism diabetes heart disease back/neck injury Parkinson's Disease lice or nits  
fainting hearing loss high/low blood pressure kidney disease Other: \_\_\_\_\_
8. Any **recent broken bones / major injuries**? If **yes**, list: \_\_\_\_\_, and circle answer → **yes none**  
**If you answered "yes" to questions 6, 7, or 8 above, please list here any camp-related ACTIVITY RESTRICTIONS:**

Attach a **separate sheet** that describes the **condition**, the **MANAGEMENT PLAN**, and **anything camp needs to do to help**.

9. Any **mental/psychological needs** that will have an impact on camp interaction/participation? Circle answer → **yes none**  
If **yes**, circle and/or list: anxiety disorder ADHD depression learning challenges oppositional defiant disorder  
eating disorder OCD bipolar disorder PTSD autism Other: \_\_\_\_\_

**If you answered "yes" to question 9 above, attach a separate sheet that describes the concern, the MANAGEMENT PLAN (including meds), and the behaviors that will indicate to our staff that the participant needs professional referral or assistance. For campers, we also need a written recommendation from a professional supporting participation in our camp program. For staff, describe on the separate sheet the support needed from your supervisor to complement your management plan.**

## HEALTH EXAMINATION: Must be Completed by a Licensed Health Care Provider

Code: √ = Satisfactory X = Not satisfactory (Explain) O = Not examined

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_ Hgb \_\_\_\_\_ Urinalysis \_\_\_\_\_ Hernia \_\_\_\_\_  
Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Teeth \_\_\_\_\_ Posture \_\_\_\_\_  
Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_ Arms \_\_\_\_\_ Abdomen \_\_\_\_\_ Legs \_\_\_\_\_

**General Appraisal:** \_\_\_\_\_ *Please review the Health History, Health Status, and Restrictions provided above.*

**For females:** Has she menstruated? \_\_\_\_\_ If no, does she know about it? \_\_\_\_\_ If yes, is menstrual history normal? \_\_\_\_\_  
To your knowledge, is the participant on any medications? \_\_\_\_\_ If yes, please list here: \_\_\_\_\_

To your knowledge, will the participant be **stopping** the use of any of these medications while they are at summer camp? \_\_\_\_\_

## Licensed Health Care Provider Please Read and Sign

I have examined the participant on (date)\_\_\_\_/\_\_\_\_/\_\_\_\_ (must be within 24 months of attending camp) and have **reviewed the health history, health status, and restrictions**. He or she is physically able to engage in camp activities, except as noted.

Health Care Provider Name (print) \_\_\_\_\_ (signed) \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (must include area code) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_