

**CAMPER APPLICATION (PATIENT) CAMP NO WORRIES**  
YMCA of Burlington and Camden Counties | 59 Centerton Rd | Mt. Laurel, NJ 08054

**GENERAL INFORMATION:**

Camper's Full Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_

Nickname or Name Child Prefers: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City / Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

Gender: M \_\_\_\_\_ F \_\_\_\_\_

\*Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Relapse Date (if applicable): \_\_\_\_\_

**\*Child Must Know his/her Diagnosis**

Parent(s)/Guardian Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Address: (if different from camper's above) \_\_\_\_\_  
Phone #: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email address: \_\_\_\_\_ Cell #: \_\_\_\_\_

**EMERGENCY CONTACTS (If parents or guardian cannot be reached)**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Pediatrician: \_\_\_\_\_ Oncologist: \_\_\_\_\_

Institution: \_\_\_\_\_ Institution: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency #: \_\_\_\_\_ Emergency #: \_\_\_\_\_

**TEE SHIRT SIZE?**  
**(Please circle one)**

**Youth Medium**

**Adult Small**

**Adult Medium**

**Adult Large**

**Adult X- Large**

**Adult XX-Large**

## MEDICAL INFORMATION

Allergies (Please list all allergies and describe the reaction and management or treatment of the reaction)

Medication Allergies

Reaction/Treatment

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Food Allergies

Reaction/Treatment

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Other Allergies (include insect bites, hay fever, asthma, animal dander, etc.)

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Please circle, does your child have any other medical problem, if yes, please describe?

ADD/ADHD

Yes

No

Asthma

Yes

No

Headaches

Yes

No

Seizures

Yes

No

History of constipation or diarrhea

Yes

No

Has your daughter begun her menstrual cycle

Yes

No

Will your daughter require assistance at camp

Yes

No

Does your child wear eyeglasses

Yes

No

Does your child wear contacts

Yes

No

Does your child wear protective eyewear

Yes

No

Does your child use a prosthesis

Yes

No

Does your child use a wheelchair

Yes

No

Does your child use crutches

Yes

No

Has your child had the chicken pox or chicken pox vaccination

Yes

No

If yes, please list disease / vaccination and date: \_\_\_\_\_

**Please note: You must alert us if your child has been exposed to any communicable disease (chicken pox, measles, mumps, shingles) 1 to 3 weeks before the first day of camp.**

**Describe:** \_\_\_\_\_

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## SPECIAL NEEDS

Please inform us of any special needs that your child has so that we can make his / her camping experiences as enjoyable and safe as possible.

Does your child function below his/her age level?	Yes	No
Does he/she attend special education classes?	Yes	No
Has your child ever been classified with having behavior problems?	Yes	No
Does your child sleepwalk?	Yes	No
Does your child suffer from nightmares?	Yes	No
Does your child awaken in the middle of the night?	Yes	No
Does your child have bedwetting?	Yes	No

If you have answered yes to any of the above, please describe:

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Please rate your child's ability to swim independently with adult supervision.

Poor\_\_ Fair\_\_ Good\_\_ Excellent\_\_

Does your child need encouragement, if so, in what way?

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Please describe in detail any physical disability and / or physical limitations:

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**PSYCHO-SOCIAL INFORMATION**

Has your child been to camp before? YES NO

If yes, please list the year and name of the camp:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

If at all possible, my child would prefer to be bunked with...

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

*(Please note: All children are bunked based on age and sex, and requests cannot always be honored).*

Have there been significant life changes for your child in the past six months? (I.e. new baby, new school, new home, divorce, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

The undersigned parent / legal guardian hereby grants permission to the medical staff or consulting physicians at Camp No Worries to administer medication and provide medical care for my child, including any medical emergency care required. I also give consent for any emergency transportation as deemed necessary.

X \_\_\_\_\_  
**Signature of Parent / Legal Guardian** **Date**

**INSURANCE INFORMATION**

Please attach a photocopy of your insurance card and prescription card, to be used for special tests, x-rays, and prescriptions.

Any specific billing instructions:

\_\_\_\_\_  
\_\_\_\_\_

**CONSENT AGREEMENT, AUTHORIZATION AND RELEASE**

This consent agreement, authorization and release must be read and signed by a parent/ legal guardian in order for your child to be eligible to attend camp.

As parent/ guardian of \_\_\_\_\_, I hereby waive and release Camp No Worries, The YMCA of Burlington County, and any co-sponsoring organizations from liability for injuries, damages, or loss of personal property.

X \_\_\_\_\_  
**Signature of Parent / Legal Guardian** **Date**