

## PROCEDURE FOR ENROLLMENT

1. Fill out the application (one for each child) and return it with the Camp fee. **FIRST TIME APPLICANTS MUST SHOW A BIRTH CERTIFICATION AS PROOF OF AGE.** Photographic copy is acceptable.
2. Have a licensed health provider examine child(ren), complete and sign the Physical Examination Forms(s). Parents/Guardians will complete and sign the Health History and Authorization for Emergency Care forms.
3. Return all completed forms to your Camp Coordinator prior to departure for Camp Lightfoot.

## CAMP LIGHTFOOT APPLICATION

Print, complete and mail all forms to address below

Baltimore, MD	Camp Lightfoot 4310 Edmondson Avenue Baltimore, MD 21229 <a href="mailto:GSCBALT@aol.com">GSCBALT@aol.com</a>	(410) 233-2385
Hampton, VA Newport News, VA	Camp Lightfoot 1816 Jefferson Avenue Newport News, VA 23607 <a href="mailto:GSCNN@aol.com">GSCNN@aol.com</a>	(757) 247-5451
New York, NY	Camp Lightfoot 220 W 145th Street New York, NY 10039 <a href="mailto:GSCNY220@aol.com">GSCNY220@aol.com</a>	(212) 283-5054
Philadelphia, PA	Camp Lightfoot 4105 Chestnut Street Philadelphia, PA 19104 <a href="mailto:GSCPA@aol.com">GSCPA@aol.com</a>	(215) 386-5051
Washington, DC	Camp Lightfoot 2006 Georgia Avenue, NW Washington, DC 20001 <a href="mailto:Gospelspreading@aol.com">Gospelspreading@aol.com</a>	(202) 387-1471

## PHYSICAL EXAMINATION

To be filled out by licensed health provider

Please print

Camper's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

CODE:      Last            First            (MI)  
           SATISFACTORY  
           NOT SATISFACTORY (EXPLAIN)  
           NOT EXAMINED

Hgt. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_ HGB Test \_\_\_\_\_ Hernia \_\_\_\_\_

Urinalysis \_\_\_\_\_ Extremities \_\_\_\_\_ Eyes \_\_\_\_\_ Glasses \_\_\_\_\_

Skin \_\_\_\_\_ Posture (Spine) \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_

Throat \_\_\_\_\_ Teeth \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

Does this child have asthma? \_\_\_\_\_ Name of Medicine \_\_\_\_\_

List other allergies and medications. \_\_\_\_\_

Recommendations and restrictions while in camp:

Special diet \_\_\_\_\_

Special medicine (name) \_\_\_\_\_

Swimming \_\_\_\_\_

Strenuous Activity \_\_\_\_\_

Other \_\_\_\_\_

IMMUNIZATION HISTORY (Please give dates)

DTP Series \_\_\_\_\_ Booster \_\_\_\_\_ MMR \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Examining Health Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Please print or type.

Examining Health Provider \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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

## APPLICATION CAMP LIGHTFOOT

Please Print

Child's Name \_\_\_\_\_ Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

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

Sex \_\_\_\_\_ Age \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home

Father's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Work

Place of Employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Home

Mother's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Work

Place of Employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

EMERGENCY CONTACT (Relative or friend other than parents)

Home

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Work

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Relationship to Camper \_\_\_\_\_

Please list dates child will attend camp \_\_\_\_\_

**The full fee is due with this application.**

**Please make check or money order payable to: CAMP LIGHTFOOT**

Amount enclosed: \$ \_\_\_\_\_

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

## CAMP BEHAVIOR POLICY

### BEHAVIOR POLICY

Persons at Camp Lightfoot are expected to behave in a manner conducive to Christian programming. Behavior deemed dangerous, inappropriate or unmanageable by the camp director or manager is grounds for dismissal from camp (for example: fighting, bullying, possession of illegal item, constant misbehavior, noncompliance, etc.). Parents will be called as needed.

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, totally agree with this Camp Lightfoot Behavior Policy.

I, \_\_\_\_\_, a camper, agree to comply with expectations, rules and procedures of Camp Lightfoot.

Today's date \_\_\_\_\_

### CAMP LIGHTFOOT RULES

- Wear shoes at all times except in bed.
- Throw only balls or play things.
- Run only in approved areas.
- Avoid rough play.
- Stay with your group.
- Obey counselors and staff.
- Avoid chewing gum.
- Avoid eating in the cabin.
- Be on time for all activities.
- Observe the lights out rule.
- Place trash in proper places.

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

Camper's Signature \_\_\_\_\_

## HEALTH HISTORY

Please Print

Camper's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First (MI)

Address \_\_\_\_\_ Apt. \_\_\_\_\_ Birth \_\_\_/\_\_\_/\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Work

Place of Employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Home

Mother's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Work

Place of Employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT (Relative or friend other than parents)

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Work

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

HEALTH HISTORY (Check giving appropriate dates)

Bed Wetting \_\_\_\_\_ German Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Measles (Regular) \_\_\_\_\_ Convulsions \_\_\_\_\_ Mumps \_\_\_\_\_

Diabetes \_\_\_\_\_ Nose Bleeds \_\_\_\_\_ Ear Infection \_\_\_\_\_

Sleep Walking \_\_\_\_\_ Fainting Spells \_\_\_\_\_

Asthma \_\_\_\_\_ Surgery \_\_\_\_\_ Serious Injury \_\_\_\_\_

List allergies \_\_\_\_\_

List current medications \_\_\_\_\_

Female camper has been told about menstruation. Yes \_\_\_ No \_\_\_

Female camper menstruates. Yes \_\_\_\_\_ No \_\_\_\_\_

Date of most recent menstruation \_\_\_/\_\_\_/\_\_\_

In case of sickness or accident, I hereby give permission to the physician or hospital selected by the Camp Staff person to hospitalize, secure proper treatment and/or tests for and to order injection, anesthesia or surgery for my child as named above.

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_