

CAMP OLMSTED REGISTRATION FORM

Child's Last Name _____ First _____ MALE FEMALE
C/O Last Name _____ First _____ Child's Date of Birth _____
Address _____ City, State _____ Zip _____
Home Phone _____ Primary Language Spoken: _____
School _____ Current Grade _____ Education: Regular Special (type) _____

2021 Season:

Session 1: June 27th – July 8th **Session 2:** July 11th – July 22nd **Session 3:** July 25th – August 5th

Has your child attended Camp Olmsted before? Yes No

How did you hear about us? Friends Flyer School Mailing Online Agency

Are you a member of a Methodist Church? (Optional) Yes No

Church/Agency affiliation (if any): _____

FAMILY DATA - For phone numbers, please circle Home, Work or Cell.

Mother's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)

Father's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)

Guardian's Name _____ Phone (_____) _____ (H / W / C)
 Check box if child lives with this person. Phone (_____) _____ (H / W / C)

EMERGENCY CONTACTS

Two people who will be responsible for the child if the parent or guardian is not available.

#1 Name _____ Relationship _____ Phone (_____) _____

#2 Name _____ Relationship _____ Phone (_____) _____

PUBLIC ASSISTANCE INFORMATION

AFDC # _____ IM CENTER _____

HEALTH INSURANCE DATA

Medicaid Number _____

Medical Plan/Insurance _____ ID or Policy Number _____

PLEASE ATTACH A COPY OF CHILD'S MEDICAID CARD OR MEDICAL INSURANCE CARD TO REGISTRATION FORM.

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Parent Comments

Is your child most comfortable speaking a language other than English? No Yes If yes, please specify:

Is your child's appetite: light average hearty Is your child a vegetarian? Yes No

What are your child's favorite foods? _____ Any **food allergies**? _____

Does your child have an EpiPen? Yes No List allergies requiring EpiPen: _____

Does your child have any other allergies? Yes _____ No

What allergy medication does your child take? _____

Does your child have asthma? Yes No Does your child have an asthma pump or nebulizer? Yes No

Can your child swim? No Yes If yes, where did he or she learn? _____

Does your child like: Art Swimming Reading Hiking Singing Dancing Nature Studies
 Cooking Drama Other: _____

Does your child: Have Nightmares Sleepwalk Wet the bed

Does your child fear: The Dark Heights Water Other _____

Has your child been away from home before? No Yes If yes, where? _____

What words would you use to describe your child? _____

Do you have any special recommendations for the care of your child? _____

Does your child have any special needs? Educational Social Emotional Other (Please Describe)

How does your child handle conflicts with adults? _____

How does your child handle conflicts with other children? _____

Is there anything else you would like to tell us about your child? _____

Signature of Parent/Legal Guardian: _____

Print Name: _____

Relationship to Child: _____

Date: _____

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www.campolmsted.org