CAMP LONG-A-COMING

Camp runs Mondays - Thursdays ★ July 8th - Thurs. August 15th <u>2024 Registration Form>>>REGISTRATION DEADLINE JUNE 20th</u> DECISTRATION MAX is 200 permana as dar't delay!

REGISTRATION MAX is 200 campers, so don't delay!

Family last name:	Parent/Guardian Name:						
Address:							
Telephone #:		Email:	_ Email:				
Child # I name:	Completing Gro	ade: Child #2 n	ame:	_Completing Grade:			
Child #3 name:	Completing Gro	ade: Child #4 n	ame:	Completing Grade:			
Emergency contact name: Phone #: Please circle your enrollment option below. Please note: Campers will only be able to attend weeks listed—weeks/days cannot be substituted.							
	I child 2 children 3 children 4 children						
4 WEEKS (7/8-8/I)	\$260	\$440	\$525	\$620	×		
6 WEEKS (7/8-8/15)	\$335	\$525	\$615	\$720			
59	South White Horse All checks shou RETURNED CHEC <u>e complete the Me</u>	e Pike Berlin, NJ 080 uld be made out to K FEE of \$25—mu	ust be paid in cash. <u>on the back. Thank</u>	ds)			

Questions? Email <u>camplongacoming@berlinnj.org</u> *Camp Long-A-Coming is NOT a Berlin Community School Program.*

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Medical Questionnaire: Please answer all questions by circling Yes or No. If the answer is Yes, please list which child it is true for.

I. Has been medically advised not to participate in any sports					
2. Is under a physician's care and the reason for such care					
3. Has experienced loss of consciousness after an injury					
4. Has experienced a fracture or dislocation					
5. Has undergone any surgery					
6. Takes any medication regularly, name of medication/reason					
7. Has allergies including hives, asthma or a reaction to bee stings					
8. Has experienced frequent chest pains or palpitations					
9. Has a history of fainting with exercise					
10. Has a history of a family member having sudden death					
II. Has any hearing loss					
					Yes / No
B. completely or	seriously impaired				Yes / No
13. Has a history of the following:	Hypertension: Yes /	No	Mononucleosis	s: Yes / No	
	Anemia: Yes / No	Tuberculosis:	Yes / No	Diabetes: Yes	/ No

If any above answers are "Yes", please describe below. (Please use a separate sheet if necessary)

Family Doctor Name: ______ Phone #:_____

In the case of an EXTREME EMERGENCY, if possible, take my child to ______ hospital.

Signature of Parent or Guardian

Date

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