-CAMP- LINCOLN

West Virginia Conservative Youth Leadership Camp Application

CAMPER INFORMATION (**PLEASE PRINT**)			
Camper Name:			
Date of birth:	T-shirt Size: S M L XL XXL	Male or Female (circle one)	Age:
First Year Camper? Yes _____ No _____	Previous Party Affiliation (if applicable): Nationalist ____ Federalist ____		
How did you hear about Camp Lincoln?			
Address:	Email:		
City:	State:	Zip:	
County:	Phone (cell):	Phone (home):	
Parent or Guardian:			
Address (if different from above):			
City, State:	Zip	Phone:	

EMERGENCY CONTACT INFORMATION	
Emergency Contact Person(s):	Relationship:
Emergency Phone Number(s):	

CAMP FEE ($250) – FEE OR SPONSORSHIP INFORMATION IS DUE WITH THIS APPLICATION		
Cash ☐	Check (make checks payable to 'Camp Lincoln') ☐	Other ☐
Sponsor Information (if applicable):		
Sponsor Organization:		
Contact Person:		Phone:
Address:		
City:	State:	ZIP Code:

SIGNATURE/RELEASE	
By signing this application I give permission for my child (ward) to attend Camp Lincoln.	
Signature or Parent or Guardian:	
Printed Name:	Date:

PLEASE RETURN APPLICATION TO: TODD GUNTER
1006 BRIDGE RD APT A
CHARLESTON, WV 25314

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PERSONAL HEALTH AND MEDICAL HISTORY
(TO BE COMPLETED BY PARENT OR GUARDIAN) PAGE 2

Camper Name:	Date of Birth:
Name of Parent/Guardian:	Phone:
If above person is not available in case of emergency, please notify:	Phone: Relationship:
Name of Physician/Health Care Provider:	Phone:
Name of Insurance Company:	Policy Number:

Please list all current medication(s) and indicate which, if any, will be taken while at camp:

Over the Counter(s):

Prescription(s)

Please list all allergies (food, plants, medications, etc.):

Allergic reactions to above allergens (if applicable):

Please check all current/past medical conditions that apply:

( )Past ( )Current Asthma
( )Past ( )Current Bleeding Disorder (if yes, please specify)_____
( )Past ( )Current Diabetes
( )Past ( )Current Convulsions/Seizures
( )Past ( )Current Fractures _____(area/how long ago)
( )Past ( )Current Headaches
( )Past ( )Current Heart Problems
( )Past ( )Current Kidney Disease
( )Past ( )Current Other: _____

Any Surgery (type(s) & complication(s), if any): Please use separate page if necessary.

_____

DIETARY NEEDS

Please list any special dietary needs (gluten sensitivity, lactose intolerance, etc.):

RELEASE

In case of emergency I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the healthcare provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child.

Signature of Parent/Guardian

Printed Name of Parent/Guardian:	Date

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