



West Virginia Youth Leadership Camp

Please fill out the following pages and return the application with the payment to Daniel Parlock at PO Box 1237 Ceredo, WV 25507. You may also scan the application and email it to parlock7@gmail.com, if payment has been pre-arranged.

Camper Name:			
Date of Birth:	Shirt size: S M L XL XXL	Gender:	Age:
First year camper? <input type="checkbox"/> YES <input type="checkbox"/> NO		Previous Party Affiliation (if applicable): <input type="checkbox"/> Nat <input type="checkbox"/> Fed	
How did you hear about Camp Lincoln?			
Address:		Email:	
City:	State:	County:	Zip:
Parent/Guardian:		Address:	
Parent Phone:		Did camper drive him or herself? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Who will be picking up your camper? <input type="checkbox"/> Parent listed above <input type="checkbox"/> Other adult (Name: _____)			
<input type="checkbox"/> N/A (Camper drove him or herself)			
Emergency Contact Information:			
Emergency Contact Person(s):		Relationship:	
Emergency Phone Number:		Alternate Number:	
Camp Fee (\$350) - FEE OR SPONSORSHIP INFORMATION IS DUE WITH THIS APPLICATION			
<input type="checkbox"/> Cash <input type="checkbox"/> Check (makes check payable to "Camp Lincoln") <input type="checkbox"/> Other: _____			
Sponsor Organization:		Contact Person:	
Phone Number:		Address:	

Signature/Release:	
By signing this application, I give permission for my child or ward to attend Camp Lincoln. I attest that I am their legal parent/guardian.	
Signature:	Date:

Personal Health and Medical History	
Camper Name:	Camper DOB:
Name of Parent/Guardian:	Phone:
Name of Physician/Health Care Provider:	
Phone:	Address:
Name of Insurance Company:	Policy Number:
Please list all current medications and indicate which, if any, will be taken at camp. Please list the appropriate time of day the medication will need to be taken (morning, noon, evening):	
Please list all allergies (food, plants, medications, etc.):	
Please check all current/past medical conditions that apply:	
<input type="checkbox"/> Past <input type="checkbox"/> Current Asthma <input type="checkbox"/> Past <input type="checkbox"/> Current Bleeding Disorder <input type="checkbox"/> Past <input type="checkbox"/> Current Diabetes <input type="checkbox"/> Past <input type="checkbox"/> Current Seizures <input type="checkbox"/> Past <input type="checkbox"/> Current Fractures (specify area and approximate date: _____) <input type="checkbox"/> Past <input type="checkbox"/> Current Headaches/Migraines <input type="checkbox"/> Past <input type="checkbox"/> Current Heart Problems <input type="checkbox"/> Past <input type="checkbox"/> Current Kidney Disease <input type="checkbox"/> Past <input type="checkbox"/> Current Other: _____	
Dietary Needs	

Please list any special dietary needs or considerations:

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:

Date: