



## Registration/Health Form

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Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Grade Entering \_\_\_\_\_ Male/Female \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

In Case of Emergency Please Notify \_\_\_\_\_ Phone \_\_\_\_\_

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Camp Dates:	Week 1 – July 10-July 14	Week 2 – July 17-July 21
C.I.T Program:	\$599/both weeks	

Payment Amount: **\$599**

**\*mail payment (check/money order) with registration to:**

*Pro-Active Summer; c/o Paul Basdekis; 45446 Conductor Terrace; Sterling, VA 20166*

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*Health History:* (Please explain any chronic or recurring illnesses or medical condition)

\_\_\_\_\_  
\_\_\_\_\_

*Present Pertinent Health Data:* (List specific allergies to food or medication and treatment. List any special dietary regimen, medicine your child is taking, psychological problems, learning disabilities, fears, difficulties adjusting to new situations, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Name and telephone number of regular physician or health care facility:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. AUTHORIZATION FOR TREATMENT: In the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Camp Director to secure and administer treatment, including hospitalization, for my child as named above.	
SIGNATURE OF PARENT OR GUARDIAN _____	Date _____



Counselor-in-Training Recommendation Form

Applicants Name \_\_\_\_\_ Date \_\_\_\_\_

Teachers Name \_\_\_\_\_

Comments:

Signature \_\_\_\_\_ Date \_\_\_\_\_