



2012 FAMILY CAMP APPLICATION

Camp Holiday Trails' mission is to **empower, encourage, and educate** children with chronic illnesses, their families, and healthcare professionals by providing a summer camp and year-round programming aimed at personal growth.

Making Summer Memories for Kids With Special Medical Needs



...In the Heart of the Blue Ridge Mountains since 1973

Camp Holiday Trails...A co-ed, residential Camp for children with special medical needs, serving children with varied diagnoses and their families.

Campers must function at a cognitive/behavioral level within 1 or 2 years of their actual age.

FAMILY CAMP CALENDAR

Please choose **ONE**:

FAMILY CAMP with the UVA Ryan White Clinic: *April 13-15*

Please contact Camp Office or UVA Ryan White Clinic for more information & application.

FAMILY HEMOPHILIA CAMP with VA Hemophilia Foundation: *May 25-27*

FAMILY CAMP MINI-WEEK: *July 29-August 1*

\$600 for family of 4, \$30 for each additional person over age 5 (contact the Camp Office for financial aid application); **DEADLINE FOR APPLICATION: June 29, 2012**

FAMILY CARDIO CAMP with UVA Pediatric Cardiology: *September TBD*

8th ANNUAL FAMILY DAY: *November 3*

Please contact Camp Office for more information & an application.

How did you hear about Camp Holiday Trails? _____

Have you ever attended Camp Holiday Trails before? Yes - What year(s)? _____ No - we're new!

400 Holiday Trails Lane · Charlottesville, VA 22903

Phone: (434)977-3781 · Fax: (434)977-8814

campisgood@campholidaytrails.org · www.campholidaytrails.org



Family Name _____



FAMILY CAMP GENERAL INFORMATION

If you have any questions or need any assistance while completing this application, our staff is here to help! Just call (434-977-3781) or e-mail campisgood@campholidaytrails.org

Family Camps at Camp Holiday Trails are for families who have **at least one child** with a special health need.
This child is the CAMPER.

A. CAMPER & FAMILY INFORMATION – ALL INFORMATION IS CONFIDENTIAL

CAMPER'S Name: _____ Gender: ___ DOB: _____

Diagnosis: _____ Cognitive/Behavioral Conditions: _____

Allergies: _____ Dietary Needs: _____ Mobility Challenges: _____

T-Shirt size (Circle one) - YOUTH size: S M L ADULT size: S M L XL OTHER: _____

Who else will we get to meet at Family Camp? (i.e. – who else is attending?)

NAME: _____ Relationship to Camper: _____ Gender: ___ DOB: _____

Medical Challenges: _____ Cognitive/Behavioral Conditions: _____

Allergies: _____ Dietary Needs: _____ Mobility Challenges: _____

T-Shirt size (Circle one) - YOUTH size: S M L ADULT size: S M L XL OTHER: _____

NAME: _____ Relationship to Camper: _____ Gender: ___ DOB: _____

Medical Challenges: _____ Cognitive/Behavioral Conditions: _____

Allergies: _____ Dietary Needs: _____ Mobility Challenges: _____

T-Shirt size (Circle one) - YOUTH size: S M L ADULT size: S M L XL OTHER: _____

NAME: _____ Relationship to Camper: _____ Gender: ___ DOB: _____

Medical Challenges: _____ Cognitive/Behavioral Conditions: _____

Allergies: _____ Dietary Needs: _____ Mobility Challenges: _____

T-Shirt size (Circle one) - YOUTH size: S M L ADULT size: S M L XL OTHER: _____

NAME: _____ Relationship to Camper: _____ Gender: ___ DOB: _____

Medical Challenges: _____ Cognitive/Behavioral Conditions: _____

Allergies: _____ Dietary Needs: _____ Mobility Challenges: _____

T-Shirt size (Circle one) - YOUTH size: S M L ADULT size: S M L XL OTHER: _____

If you need additional space (for more info OR more people), please attach another page.

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Family Name _____

B. CONTACT INFORMATION

Who will be the primary contact for Family Camp?

Name: _____

Address: _____

(Street)

(City)

(State)

(Zip code)

E-mail: _____ Primary Phone #: (____) _____

We need to be able to reach families by **both** phone & email.

Who will be your emergency contact (must be someone not attending the camp) while you are at camp?

EMERGENCY CONTACT Name: _____

Relationship to your family: _____ Email: _____

Home Ph. # (____) _____ Cell Ph. # (____) _____ Work Ph. # (____) _____

C. CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the medical staff of Camp Holiday Trails to provide routine and emergency medical services as required for myself, and/or for my child(ren). I assume full financial responsibility for any and all medical and other expenses incurred on my behalf while at CHT and understand that CHT shall not be liable for any such expense. I understand that information pertaining to myself and my family will be treated as confidential by CHT, but that information may be shared or released with appropriate personnel by CHT for the purpose of treatment. I agree to release CHT and its sponsors, volunteers, employees, directors, and all agents of any liability arising from the administration or rendering of care. This form may be photocopied for use outside of camp.

NAMES (Please print full names of ALL attending):

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

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Family Name _____

D. INSURANCE INFORMATION

Who is your primary insurance provider?

Name of company: _____ Medicaid #: _____

Address: _____ Policy #: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Group Insurance? Company name: _____

Parent/Guardian who insures children: _____

Social Security # of Parent/Guardian who insures children: _____

E. CONSENT FOR PHOTOGRAPHS

I give CHT, sponsors, and authorized news media permission to **photograph and to use pictures**, video, or audio tapes of my family for the newsletter, fundraising, and positive promotional activities and to help the community understand and support children with special health needs. CHT respects the privacy of all participants and does not give permission for unauthorized visitors to photograph campers or families.

Parent/Guardian Initials: _____

F. ALCOHOL, TOBACCO AND DRUG-FREE CAMP

Camp Holiday Trails is committed to the health and safety of all participants and staff.

- ☞ We do not allow alcohol on the premises at any time.
- ☞ We do not allow tobacco products to be used at any time. This includes smokeless tobacco. There is no smoking, dipping, or chewing—even in your vehicle—while on camp premises. If you would like assistance with the symptoms you may be feeling due to this policy, please see our Med Staff.
- ☞ We do not allow any form of illegal drugs on the premises at any time.
- ☞ **We reserve the right to ask anyone to leave if any of the above items are brought to camp.**

G. PARENT/GUARDIAN SIGNATURE

I have completed sections A through F of this application to the best of my knowledge. I understand that incomplete or inaccurate information may result in the inability of our family to participate in the Camp Holiday Trails program.

Name of person who completed this application: _____
(if different from Parent/Guardian)

Relationship to family: _____ Contact info: _____

Parent/Guardian Signature

Date

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