

2019 Spartan Day Camp Application

Camper's Name: _____ Parent's Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ Development: _____

Home Phone: _____

Work Phone (Mr.): _____ Work Phone (Mrs.): _____

Email: _____

Emergency Contact & Number: _____

School Attending: _____

Grade during school year just completed: _____ Birth Date: _____

Age: _____ Male: Female: Return Camper: New Camper:

Application should be returned with \$75 non-refundable deposit (\$50 for each additional camper) which will be applied to your child's final week's tuition to:

Matt Smith, Director
Spartan Day Camp
2501 Pike Creek Road
Wilmington, DE 19808

For Further information call Matt Smith at: 302.757.8716

CHECK OFF WEEKS OF EXPECTED ENROLLMENT:

Dates	Before Camp	After Camp
<input type="checkbox"/> June 17 – 21	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> June 24 – 28	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 1 – 5*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 8 – 12	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 15 – 19	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 22 – 26	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 29 – Aug. 2	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> August 5 – 9	<input type="checkbox"/>	<input type="checkbox"/>

* NO CAMP ON JULY 4th

Camper's Name: _____

The Division of Public Health for the State of Delaware does not require day campers to furnish a report of physical examination; however, a medical history including allergies, other health conditions, and current immunizations are required and must be kept on file at the camp. Please complete the following:

IMMUNIZATION HISTORY

(THIS IS A RECORD OF DATES OF BASIC IMMUNIZATIONS AND MOST RECENT BOOSTER DOSES.)

DTP SERIES _____ BOOSTER _____ BOOSTER _____
POLIO OPV _____ BOOSTER _____ TYPHOID _____
(SABIN) MEASLES VACCINE (LIVE) _____ TUBERCULIN _____
GERMAN MEASLES _____ MUMPS VACCINE _____
(RUBELLA) SMALLPOX _____ OTHER _____

HEALTH HISTORY

ALLERGIES DISEASES

HAY FEVER _____ CHICKEN POX _____ POISON IVY _____
MEASLES _____ INSECT STINGS _____ GERMAN MEASLES _____
PENICILLIN _____ MUMPS _____ OTHER DRUGS _____
ASTHMA _____

OPERATIONS OR SERIOUS INJURIES (DATES) _____

CHRONIC OR RECURRING ILLNESS _____

OTHER DISEASES OR DETAILS OF ABOVE _____

ANY SPECIFIC ACTIVITIES TO BE RESTRICTED _____

This health history is correct so far as I know, and the person herein described has my permission to engage in all camp activities, except as noted by me above.

I understand that part of the camping experience involves activities, group living arrangements and interactions that may be new to my child. These things come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free and so I have instructed my child on the importance of abiding by the camp's rules. My child and I both agree that he or she is familiar with these rules and will obey them.

In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named on the reverse side.

SIGNATURE _____ DATE _____

Your signature below grants permission for your child to roller skate at Christina Roller Rink on scheduled days once a week. We have use of the rink on Fridays for all campers. A fee of **\$3.00** is due the day of skating.

Also, the signature gives the camp permission to use any photo taken of your child while participating in camp activities in publications, on the camp website and other social media outlets.

SIGNATURE _____ DATE _____