

**COLLEGE OF YOGA SCIENCES**

**DAY CAMP**

**Camper's Application Form**

**Mail to: Mr. Om Baweja, 113 Econlockhatchee Trail, Orlando FL 32825 TEL 407-275-0013**

Please fill out separate form for each child.

Camper's First Name: \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth (mm/dd/yyyy) : \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Phone (Office): \_\_\_\_\_

Phone (Emergency): \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Comments/Suggestions: \_\_\_\_\_

\_\_\_\_\_

**Parent's Consent**

- I hereby release College of Yoga Sciences, HUA and its officers of any liability for any accidents or injuries my child may incur while attending the Camp.
- I and my health insurance company are completely responsible for the payment of all expenses incurred for any kind of medical and/or surgical treatment as a result of my child's participation in the camp.
- In the event of an emergency where treatment by a doctor is deemed necessary, I hereby give permission for a representative of the College of Yoga Sciences, HUA to authorize physician(s) and hospital personnel to give my child anesthesia and/or perform whatever medical and/or surgical treatment deemed necessary at such time in my child's best interest.

Signature of the Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**\$65 for 5 days from 8:00am to 5:00pm**

**PS – Kindly make checks payable to College of Yoga Sciences, HUA**

**COLLEGE OF YOGA SCIENCES**

**MEDICAL 1**

**DAY CAMP**

**Medical Form**

Name of Participant: \_\_\_\_\_

Date of Birth (mo/day/yr): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact's Phone(s): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Medical Insurance co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Health History: Check those that apply and explain any illness checked below or attach a sheet:**

Chicken Pox	___ Yes ___ No	Learning Difficulties	___ Yes ___ No
Measles	___ Yes ___ No	Physical/Social/Emotional Needs	___ Yes ___ No
German measles	___ Yes ___ No	Hypertension	___ Yes ___ No
Mumps	___ Yes ___ No	Asthma	___ Yes ___ No
Mononucleosis	___ Yes ___ No	Bleeding Disorders	___ Yes ___ No
Seizure	___ Yes ___ No	Diabetes	___ Yes ___ No
Epilepsy	___ Yes ___ No	Operations/Serious Injuries.	___ Yes ___ No
Ear Infection	___ Yes ___ No	Chronic/Recurring Illness	___ Yes ___ No
Heart Disease/Defect	___ Yes ___ No	Dietary Restrictions	___ Yes ___ No
Musculoskeletal Disorder	___ Yes ___ No		

**Allergies (list)**

Food	___ Yes ___ No	Animal	___ Yes ___ No
Drug	___ Yes ___ No	Hay Fever	___ Yes ___ No
Insect Sting	___ Yes ___ No	Plant/Pollen	___ Yes ___ No

Other: \* \_\_\_\_\_

**COLLEGE OF YOGA SCIENCES**

**MEDICAL 2**

**DAY CAMP**

**Camper's Application Form**

Name of Participant: \_\_\_\_\_

Special Conditions to be watched for (i.e. wetting, fainting, menstrual cramps, etc.) \*: \_\_\_\_\_

Hospital / Emergency visit during the last 6 months? : \_\_\_\_ Yes: \_\_\_\_ No: If yes then for what reason? \* \_\_\_\_\_

This health history is correct as far as I know and the person described has permission to engage in all camp activities except as noted above. I will notify Camp authority if there is any change in health conditions of the participant.

**I give permission:**

- 1) To the medical personnel selected by the Camp authority to hospitalize, secure proper treatment such as anesthesia or surgery, and to provide or arrange necessary transportation for the participant.
- 2) For Camp Health Supervisor to treat minor injuries or illness as directed by orders of a licensed physician; administer Prescription medication brought to camp in it's original container, labeled with the participant's name, physician' name and dosage; and/or administer over- the- counter medication unless otherwise specified below.

**Medications:** List of over-the-counter medication that **may not** be administered to the participant: \*

The participant does **NOT** take any medication on a routine basis: \_\_\_\_\_

The participant takes the following medicines (Please include ALL medications and attach sheet for more): \*

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Signature** (Parent or Guardian for participant under 18) \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by Licensed Physician or State Approved Nurse Practitioner**

Name of Participant: \_\_\_\_\_

Date of Examination (must be within last two years): \_\_\_\_\_.

In my opinion, this person's condition allows participation in active camp program subject to the following limitations, restrictions, and treatment to be continued at the camp: