



June 13-18
2010
Deadline May 20

<i>Office Use</i>

MO-OK Deaf Youth Camp
Ages 10 through High School

Name	Age	Male	Female
Address			
City	State	Zip	

Parent/Guardian

Name		Home Phone				
Email		Work Phone		Mobile Phone		
Address			City		State & Zip	
Name of Employer			Family's Religious Preference			
<i>Check all that apply.</i> Does the camper use: <hr/> Does camper use a sign language interpreter at school?	ASL	PSE	SEE	Lip read	Both	Oral
	Yes	No				

Camp T-shirt order form. All sizes listed are Adult

Small	Medium	Large	X-Large	XX-Large	XXX-Large
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Only forms received by May 20, 2010 deadline can be guaranteed a t-shirt in the correct size.

Emergency Contact *If parent or guardian cannot be located, in case of emergency*

Name	Contact Number
Persons authorized to take child from camp (other than parent/guardian)	
Persons not permitted to take child from camp	
Authorization to participate in camp activities I hereby give permission for my child to go on field trips away from camp premises, whether on foot or by vehicle.	
<hr/> <i>Parent or guardian signature</i>	<hr/> <i>Date</i>



Office Use

Permission form and Health form

Check all that you are authorizing and then sign and date

Camper's Name _____	Birth date / /
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Permission to Photograph/Video -Deaf Youth Camp may produce a video of camp week and/or put pictures of different activities on DYC website. No names will be used. By checking this box you give DYC permission to video and/or photograph your child.

I give Missouri Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out by parent/guardian. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected for my child and will accept the expense of emergency medical or surgical treatment.

Information on this form is to assist in identifying appropriate care. This is to be completed by parent/guardian.

1. Communicable diseases, surgeries and/or serious illnesses

2. Chronic or recurring illness or medical condition

3. Special dietary requirements and/or restrictions

Insurance

Name of policy holder _____ Phone _____
Policy/Group # _____ Type of coverage _____
Please include a copy of your insurance card.

Immunization Record

Vaccine	Month and Year
Diphtheria-Tetanus-Pertussis	_____
Tetanus - Diphtheria (TD)	_____
Tetanus	_____
Polio	_____
Measles (Hard, Red)	_____
Rubella (German)	_____
Mumps	_____
Other	_____

Check all that apply

Allergies	Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Dust	Other
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Camper's Name

Check all that apply

<i>Asthma</i>	<i>Diabetic</i>	<i>Takes cold easy</i>	<i>Sunburns easy</i>
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Medicine	Dose	Time administered/X per day	Office use

I give Missouri Deaf Youth Camp's nurse permission to administer the following over the counter medications as need according to the manufacturer's directions. Please check all you authorize to be given as needed.

Tylenol	Ibuprofen	Chloraseptic spray	Halls Cough Drop	Caladryl Lotion	Antibiotic Ointment
Sunburn spray/lotion with lidocain					

In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by the camp Administrator, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child and will accept the expense of emergency medical or surgical treatment.

Signature

Date

Relationship

Please list as much as possible about your insurance and the deductible. Send a copy of your registration and complete Camper Health form and check/money order to:

**Marsha Averill
9443 High Hill
St Louis, MO 63126**

Registration fee: \$90.00

Checks should be made out to: MBCD/Deaf Youth Camp

DEADLINE for receiving application and fee is May 20, 2010