

Lime Hollow Nature Center
338 McLean Road, Cortland, NY 13045
Telephone/ Fax 607.662.4632
www.limehollow.org / E:info@limehollow.org

Please Circle Week(s)
1 2 3 4 5 6 7 8 9 10

Camp Gracie Half Day ONLY (ages 3-5)

Parents: Please complete, sign and return application with a **deposit of 50% of cost of camp.** **Refund Policy:** Refunds will be given until one week prior to session. There will be a \$25 administration fee for all cancellations.

Camper's Name: _____ M F (circle one)
Camper's Age: _____ Birth date: _____ Grade _____ Member: Y or N (circle one)
Parent/Guardian: _____ Phone(h) _____ Cell _____
Parent/Guardian: _____ Phone(w) _____ Cell _____
Address: _____ *
Email: _____

*Lime Hollow respects your privacy. All information we obtain is kept confidential.

EMERGENCY CONTACT, in the event the parent/guardian cannot be reached:

Name: _____ Phone: _____ Cell _____
Address: _____ Relationship: _____

HEALTH HISTORY, please check giving approximate dates or current status:

Hay Fever _____	Hepatitis _____	Heart Murmur _____
Poison Ivy _____	Measles _____	Chronic / Recurring Illness _____
Insect Stings _____	Rheumatic Fever _____	Penicillin Allergy _____
German Measles _____	Influenza Type B _____	Fainting _____
Mumps _____	Diphtheria _____	Food Allergies _____
Diabetes _____	Seizures _____	Operations/Serious Injuries _____
Chicken Pox _____	Asthma _____	Other drug allergies _____

Please list details of above and any physical condition or activity restrictions that should be known to staff: _____

Is this camper under medical care for any reason? () Yes () No

If 'Yes' please specify: _____

Does camper regularly take any medication? Please specify: _____

Medication (including non-prescription) must be given to Camp Director by parent/guardian on the first day of the session.

IMMUNIZATION HISTORY, in order for campers to attend camp, the parent/guardian must list specific dates for each of the following immunizations. Failure to document these dates are grounds for non-acceptance of camper registration.

DPT _____	Booster _____	Polio (IPV or OPV) (Sabin) _____	Booster _____
Varicella (Chickenpox) _____		Haemophilus influenza type b (Hib) _____	
Measles, Mumps and Rubella (MMR) _____		Hepatitis B _____	
Other _____			

Child's physician _____ Phone _____

Address _____

TO BE COMPLETED BY PHYSICIAN: Optional, unless your child has a serious illness or has had surgery within the last year. In this case, he/she must have this signed permission to attend camp. *I consider this child to be in good health at this time, and believe he/she is physically able to participate in day camp activities.*

Signature of Licensed Physician _____ Date _____

PARENT/GUARDIAN AUTHORIZATION: *This health history is correct so far as I know, and the person herein described has permission to participate in all day camp activities, except as noted by me or examining physician. In an emergency, when the undersigned or other named person cannot be contacted, I hereby authorize the Camp Director to take any action deemed necessary for the best interest of my child*

Signature of parent/guardian _____ Date _____

I hereby grant Lime Hollow permission to use photographs taken over Summer Camp 2012 in any and all publications.

Signature _____ Date _____