Valley Day Camp

Camper Intake Form

(Please Print)

Today's date:	Counselor:

CAMPER INFORMATION

Parent's/Guardian's Last Name: First: Middle:	Camper's Age:	Sex: ❑ M ❑ F	Birth date: / /

Parent's Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Camper's Full Name:

Do you have more than one child enrolled in Valley Day Camp? ❑ Yes ❑ No If yes: full name of sibling:

Street address:	Social Security No.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

School:	Grade: IEP: ❑ Yes ❑ No If yes: please attach copy or description of IEP	School Phone Number: ( )

Referred to VDC by or heard about VDC through (please check any that apply and specify):

❑ Counselor/Therapist:	❑ Physician/Psychiatrist:	❑ Radio station/Newspaper:
❑ Facility/Agency:	❑ School/Guidance Counselor/Teacher:	❑ Other:

EMERGENCY AND MEDICAL INFORMATION

Camper's Name	Birth date: / /	Address:	Home phone no.: ( )

Pediatrician:	Address:	Pediatrician phone no.: ( )

Does the camper have any medical problems? ❑ Yes ❑ No If yes, please describe:

Please list allergies:

To food:	Seasonal:	Bees:	Medications:

Please describe/list allergy medications or treatments (emergency and non-emergency):

Does the camper have any medical restrictions regarding physical activities?	❑ Yes	❑ No

If yes, please specify:

Please provide emergency contact information:

Name	Phone Number	Address	Relationship to camper
1)			
2)			

FINANCIAL INFORMATION (TO BE FILLED OUT IF REQUESTING FINANCIAL AID)

Gross Annual Household Income: Number of Dependents: Other Sources of Income:

Please list any extenuating circumstances:

The above information is true to the best of my knowledge. I acknowledge that I am financially responsible for the camp fees as agreed upon at the evaluation session. I understand that I may cancel my registration up to 30 days before the session start date for a full refund less $25.

Patient/Guardian signature *Date*

PRESENTING CONCERNS

Please list your child's symptoms, challenges, and diagnoses (if applicable):

_____
_____
_____
_____
_____
_____

Please list your child's strengths and interests:

_____
_____
_____
_____
_____
_____

Please let us know what your goals and hopes are for your child as a result of involvement in VDC:

_____
_____
_____
_____
_____

CAMPER INPUT SECTION

What do you like to do for fun?

_____
_____

What is your favorite thing to do in the summer?

_____
_____

What do you like about yourself?

_____
_____

If you could get help with something about yourself, your feelings, or your behavior, what would you want help with?

_____
_____

MEDICATIONS

Name of Medication	Prescribing Doctor	Dosage	Reason for medication

HOUSEHOLD MEMBERS

Please list all of the people who live with the child.

Name	Relationship to child	Age

CURRENT MENTAL HEALTH TREATMENT

Type of treatment	Name	Address	Phone Number
Psychiatrist			
Therapist/Counselor			
Agency/Facility Name			
Recent Hospitalizations			
Other			

AUTHORIZATION FOR TREATMENT

I understand that my child's involvement and treatment at Valley Day Camp is completely voluntary and I consent to his/her treatment at this facility.

_____ _____

Signature (Parent/Guardian) Date

_____

Print Name

_____

Name of child

ADDITIONAL INFORMATION

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