CAMP SPAULDING INTAKE

CAMPER INFORMATION

First name: MI: Last name:

School: DOB: Age at camp: Gender: M F

Former Camp Spaulding camper? ☐ YES ☐ NO Session(s) preferred 1 2 3 4

Ethnicity (optional)

PARENT/GUARDIAN INFORMATION

First Name: MI: Last Name:

Address: City/Town: State: NH Zip:

Home#: E-mail: Work#:

Person to contact in emergency (other than parent/guardian):

Relationship to child: Home# Work#:

REQUIRED HOUSEHOLD INFORMATION

Annual household income: Total living in household:

Primary language:

Status of adult(s): ☐ Single ☐ Married ☐ Live-In Partner ☐ Divorced ☐ Separated ☐ Widowed

FINANCIAL/HOUSEHOLD INFORMATION (PLEASE LIST ALL HOUSEHOLD MEMBERS)

Name	DOB	Gender	Relationship to camper	Name of employer or source of income (SSI, TANF, child support)	Gross income

OFFICE USE ONLY

Camper Name	Sessions	SFSP	Fee/Session	Total	Date Rec'd	$ Rec'd	Balance

INSTRUCTIONS FOR APPLYING

A household member is any child or adult living with you.

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP OR FANF, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members, the school name for each child, and the case number for any household member (including adults) receiving **SNAP** or **FANF** benefits.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.

IF NO ONE IN YOUR HOUSEHOLD RECEIVES **SNAP** OR **FANF** BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the school name for each child.
Part 2: Check the appropriate box.
Part 3: Skip this part.
Part 4: Complete only if a child in your household isn't eligible under Part 2. See instructions for All Other Households.
Part 5: Sign the form. A Social Security Number is not necessary if you didn't need to fill in Part 4.
Part 6: Answer this question if you choose to.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

Part 1: Use a separate application for each foster child. List the child's name, school, and, if the child has no income, check the box "no income."
Part 2: Skip this part.
Part 3: Check the box and list the child's personal use monthly income, if any.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the school name for each child. For any person, including children, with no income, you must check the "No Income Box."
Part 2: Check the appropriate box, if any.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.

- **Box 1–Name:** List all household members with income.
- **Box 2 –Gross Income and How Often It Was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the **gross income,** not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, and *All Other Income* sources. Under *All Other Income*, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last 4 digits of their Social Security Number (or mark the box if s/he doesn't have one).
Part 6: Answer if you choose.

Important - please read

Due to funding limitations for areas outside Merrimack County, and in an effort to extend a camping experience to more children from these out of district areas, we will be restricting the number of sessions allowed to one per child We will gladly place your child's name on a waiting list for a second session as space and funding allows.
Merrimack County residents may still attend up to two sessions.

Acceptable forms of income verification

If you are employed:
4 most recent, consecutive paycheck stubs if hours vary
1 most recent paycheck stub if work 40 hours weekly
W2 if still working for same employer and you worked full year with that employer.

If you receive TANF benefits:
Your caseworker can provide you with a current summary sheet, which notes both cash benefit and food stamp benefit.

If you receive
Social Security/Survivior/Disability benefits:
You can request a current summary of your yearly benefits.

Tax returns will only be accepted if professionally prepared and your income is about the same.

Please note: If you are unable to provide any form of income verification, you will be expected to pay the full camp cost. Once verification is provided, we will gladly adjust your fee at that time.

Camp Spaulding Sliding Fee Scale

Family Income	Number of Family Members						
	2	3	4	5	6	7	8
$1-10,000	$50	$50	$50	$50	$50	$50	$50
$10,001-15,000	$75	$60	$50	$50	$50	$50	$50
$15,001-20,000	$150	$120	$90	$75	$60	$60	$50
$20,001-25,000	$225	$150	$120	$90	$75	$60	$50
$25,001-30,000	$300	$225	$175	$125	$100	$75	$60
$30,001-35,000	$425	$300	$225	$175	$150	$100	$75
$35,001-40,000	$550	$425	$300	$225	$175	$150	$100
$40,001-50,000	$650	$550	$425	$300	$225	$175	$150
$50,001-60,000	$750	$650	$550	$425	$300	$225	$175
$60,001+	Full cost of camp $900.00						

INCOME ELIGIBILITY FORM FOR SCHOOL YEAR
(For use by Camp Spaulding)

Part 1. Children or adults enrolled to receive day care. (Use a separate application for each foster child)

Names (First, Middle Initial, Last)	Food Stamp, TANF or FDPIR case # for children only. All the above or SSI or Medicaid case # for adults only. **Skip to Part 4 if you listed a case #**

Part 2. Foster Child: In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If foster children live with you, please contact **[name]** and **[phone number]**. Skip to Part 4.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
(Example) Jane Smith	$200/weekly_____	$150/weekly_____	$100/monthly_____	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	
	$______/________	$______/________	$______/________	$______/________	

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X________________________________ Print name:____________________________

Date: _________________

Address:____

Phone Number:__________________________

Social Security Number: X X X - X X - __ __ __ __   ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____________ Per: q Week, q Every 2 Weeks, q Twice A Month, q Month, q Year   Household size: __________

Categorical Eligibility: ___ Date Withdrawn: _________ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: ____

Temporary: Free_____ Reduced_____ Time Period: _______________________________(expires after _____ days)

Determining Official's Signature: ____Date: ______________

Confirming Official's Signature: ____Date: ______________

Follow-up Official's Signature: ____ Date:______________

Household size	Yearly
1	$ 20,036
2	$ 26,955
3	$ 33,874
4	$ 40,793
5	$ 47,712
6	$ 54,631
7	$ 61,550
8	$ 68,469
Each additional person:	$ 6,919

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

SUMMER FOOD SERVICE PROGRAM
NOTICE OF HEARING RIGHT AND PROCEDURES

(to be included with denial of either free or reduced price meals, snacks or milk approval)

Right to Appeal

Any person who is not satisfied with the decision of the Approving Official regarding eligibility for Free or Reduced Price Meals or Free Milk may appeal and receive a hearing. A Hearing Officer will hear your appeal and make a decision.

Hearing Procedures

1. If you want to appeal the decision of the approving official regarding meal/milk benefits, you should request a hearing.

2. You have the right to examine, before the hearing, any records concerning your child's eligibility. This includes any documents and records presented to support the decision under appeal.

3. You may request an informal meeting with a Sponsor representative prior to the hearing.

4. The hearing will be scheduled with reasonable promptness. If possible, it will be held at a time, place and date convenient for you. You will receive written notice of the hearing schedule.

5. You may choose to be represented at the hearing by an attorney or a friend. You may represent yourself.

6. At the hearing, you have the right to present oral and written evidence to support your appeal and to present witnesses to testify for you.

7. You have the right to question any witnesses presented by the Sponsor and refute any testi mony or evidence presented by the Sponsor.

8. The hearing will be conducted by the Hearing Official who did not participate in making the Sponsor's decision to deny your child's application.

9. The decision of the Hearing Official will be based only on the evidence presented at the hearing.

10. You will be notified in writing by the Hearing Official of the decision concerning your appeal.

11. The decision of the Hearing Officer will be the final administrative decision. You have the right to appeal any adverse decision to the Superior Court within thirty (30) days of the decision.

12. A written record of the hearing and the decision will be maintained and will be available for examination for a period of three (3) years plus the current year.

Your Child's Health

Dear Parents:

WELCOME! The health staff of Camp Spaulding welcomes you. Our priority is the health and safety of all campers. In order to ensure this, we ask your cooperation in helping us get to know your child.

A health history and physical are mandatory to attend camp, as it is State law that we cannot accept campers without complete health information signed by both a parent/guardian and his/her physician. Please use the following guidelines to ensure that your child's health information is submitted properly:

1. You, the parent/guardian, must complete and sign pages 1 and 2 of the health information packet. Pages 5 & 6 must also be signed if your child is prescribed medications and/or uses an Epi-pen or an inhaler.

2. Your child's physician must complete and sign pages 3 and 4 of this health form, as well as pages 5 and 6 if your child is prescribed medication and/or will have an Epi-Pen or an asthma inhaler in his/her possession while at camp. By law, every camper must have an actual physical dated within 24 months prior to the date of the session he/she is registered to attend AND an examination within twelve months of the start of the session. An examination for some other purpose within this period is acceptable as long as the physician is able to determine your child's fitness to engage in strenuous and general camp activities.

3. Mail the completed and signed health packet to Child and Family Services, P.O. Box 448, Manchester, NH, 03105. You can no longer bring this health information to camp on check-in day. If there are any changes to your child's health after the forms are submitted, you may discuss these changes on check-in day with the health staff.

4. Over the counter medication: For the safety of all campers and staff, no-one is allowed to keep prescription or over-the counter (OTC) medications with them. The exceptions to this rule are inhalers for asthma and Epi-Pens for severe allergies. For these, one must be kept, by law, with the medical staff, but a SECOND one can be kept by the camper as authorized by the child's physician on page 5 of this packet. A parent/guardian signature is required as well. You are still required to check in with nurses upon arrival/drop off. This rule assures that your child will receive prescribed medication on a monitored basis and it keeps medication out of the hands of other children. We also stock over-the-counter medications such as acetaminophen, ibuprofen, antihistamines, cough/cold remedies, and antacids. We dispense these medications on request, as deemed necessary, so there is no reason for any camper to keep medications in his/her cabin.

5. Camp Spaulding will attempt to make necessary adjustments to accommodate your camper's health needs, however we are currently unable to accommodate certain types of food allergies and other medical conditions. Please contact Ed Orlowski LICSW, program director, 603-518-4330 or 800-640-6486 ext. 4330, if you have specific concerns about Camp Spaulding's ability to accommodate your child's needs.

CAMP SPAULDING
CAMPER MEDICAL FORM

125 River Road-Penacook, NH- (603)753-8990

NON-PROFIT SUMMER CAMP PROGRAM FOR N.H. YOUTH

Please PRINT all information clearly. Return completed form to: Child and Family Services, P.O. Box 448, Manchester, NH, 03105, two weeks prior to start of camp session.

HEALTH HISTORY & PERMISSION TO TREAT

Please read – This health information is MANDATORY to attend camp, as we cannot BY LAW accept campers without completed health information signed by both a parent/guardian and physician. The information on the following pages is necessary for the care of your child should he/she become sick or injured at camp.

CAMPER NAME (PLEASE PRINT) Last: ______ First: ______ MI ______

Identifying Information

Child last name: ______________________________ First name: __________________________ MI: ______

Date of birth: _____/____/____ Age as of 6/1: _____ Social Security #:________________________ Sex: M F

Parent/Guardian name: ___________________________________ Relationship to child: __________________

Home address: ____

Street City State Zip

Home phone: _________________________Business phone:___________________ Cell phone:______________

If not available in an emergency, please notify: ____

Relationship to the camper: ____

Home phone: _________________________Business phone: _________________Cell phone: ______________

Insurance Information

Is child covered by health insurance? (circle one) YES NO If yes, please provide the following:

Name of medical insurance company: ____

Medical insurance identification number: ____

Subscriber or policy holder name: ____

Primary care physician name: ____

Physician's telephone number:____

Health History

Drugs/environmental allergies? Yes____ No____ If yes, please list ________________________________

Dietary allergies? Yes______ No______ If yes, please list

____

____

____

Chronic/recurring illnesses? Yes _____ No_____ If yes, please describe: ______________________________

____

Serious injuries/illnesses/operations? Yes ______ No ______ If yes, please describe & provide dates: ________

____

Has your child had Chicken Pox? Yes _____ No _____ If yes, in what year? ____________________________

Is child coded as: ADD _______ ADHD _______ or Other ______ If other, please describe ____________________

____

Name of child's Dentist: ______________________________________ Phone number: ___________________

Authorization to Treat or Seek Treatment

All information, health history, and physician's examination on this medical form is correct so far as I know, and the child herein described has permission to engage in all prescribed camp activities, except as noted by me, his/her parent/guardian, and examining physician. In the event that I, the parent/guardian, cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Spaulding Executive Director or Nurse to secure proper treatment for a medical problem or injury and to order injection, anesthesia, hospitalization or emergency surgery for my child as named above and as indicated on this medical form.
This completed form may be photocopied for trips out of camp.

Signature of parent or legal guardian: ____

Date: ________________________________

Authorization to Dispense Over-the-Counter Medications

I do hereby authorize the camp nurse, or his/her designee, to administer over the counter medications as deemed necessary in accordance with the Camp Spaulding standing doctor's orders.

Signature of parent or legal guardian: ____

Date: ________________________________

PHYSICIAN'S STATEMENT & IMMUNIZATION RECORD

Camper's name: ____Date of birth: _____/_____/_____

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diptheria	1.	1.
Pertussis DPT*	2.	2.
Tetanus	3.	3.
OR		
Tetanus		
Diptheria TD*		
OR		
Tetanus		
Oral Polio (Sabin) TOPV*		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus influenze b (HIB)		
Hepatitis B (HPV)		

Health care recommendations by licensed physician

Date of last physical examination: ___/___/___ Date of last examination for any other reason ___/____/____

Brief reason for this examination: ____

Height: __________ Weight: ____________ Blood pressure: ___________

The above is under the care of a physician for the following condition(s): ______________________________

____

Current treatments (include current medications): ____

Any treatment to be continued at camp: ____

Does the above-named have diabetes? Yes_____No _____ Epilepsy? Yes _____ No _____

Are there any physician recommendations and/or restrictions for this child while at summer camp relative to:

Special diet: _______ Swimming/diving: ______ Strenuous activities: ______

Other (please describe): ____

In your opinion, the condition of the camper named above _____ does ____does not preclude participation in an active camp program.

Additional health information we should be aware of: ____

____

(For female child only)

Has this child menstruated? Yes _____ No _____

If not, has she been told about it? Yes ______ No ______

If so, is her menstrual cycle normal? Yes _____ No _____

Any special considerations? ____

____

Licensed physician's signature____Date___________

Address: ____
Street City State Zip

Date of form completion: ___________________ By:________________________________
*Initial if completed by nurse or physician's asst.

CAMP SPAULDING SUMMER CAMP PROGRAM
MEDICATION PERMISSION AND RELEASE FORM

Note:
This page must be completely filled out and signed by BOTH parent/legal guardian and physician (that treats child as indicated on the medical form) if the child is on any medication that would need to be dispensed during their stay at Camp Spaulding. If there are any changes in either the medication(s) or dosage(s) as indicated by the physician below prior to arriving at the camp, the parent/legal guardian MUST HAVE IN WRITING these changes from the prescribing physician in hand and be given to the camp nurse during check-in on the first day of camp. The child will not be accepted into Camp Spaulding without this Note of Change in medication(s) or dosages(s) from the prescribing physician.

Child's prescription medication information-To be filled out by child's physician only

1. Name of child, under your care:________________________________ D.O.B __________
(First) (Last)

2. Is the child coded as:(check one) ❑ ADD ❑ ADHD or ❑ Other or N/A
List other____

3. Name(s), total daily dosage and medical reason(s) for medication(s) to be dispensed while the child is at Camp Spaulding.

NAME OF MEDICATION	TOTAL DAILY DOSAGE	MEDICAL REASON FOR MEDICATION
1.__________	__________	__________
2.__________	__________	__________
3.__________	__________	__________

Daily Schedule – For Dispensing Medication(s), Listed Above By Physician: (please print clearly)

NAME OF MEDICATION	TIME MEDICATION IS DISPENSED	DOSAGE OF MEDICATION AT THIS TIME
MORNING:		
1.__________	1.__________ AM	1. __________
2.__________	2.__________ AM	2.__________
3.__________	3.__________ AM	3.__________
AFTERNOON:		
1.__________	1.__________ PM	1. __________
2.__________	2.__________ PM	2.__________
3.__________	3.__________ PM	3.__________
EVENING:		
1.__________	1.__________ PM	1. __________
2.__________	2.__________ PM	2.__________
3.__________	3.__________ PM	3.__________

PHYSICIAN'S SIGNATURE:________________________________M.D. DATE:________

PARENT/LEGAL GUARDIAN SIGNATURE____________________________ DATE:________

PERMISSION TO POSSESS & USE PEINEPHRINE AUTO INJECTOR AND/OR ASTHMA INHALER FOR EMERGENCY CARE

Attention Parents – This form must be completed in its entirety and signed by a parent/guardian AND physician in order for your child to personally carry an Epi-Pen and/or an emergency inhaler while at camp.
THIS SECTION TO BE COMPLETED AND SIGNED BY PRESCRIBING PHYSICIAN:

Camper's name: ____Date of Birth: ____________

Diagnosis requiring Epi-Pen/emergency inhaler: ____

Are there any other medical conditions? Yes ______ No ______ If yes, please list: __________________
____

The following information about the medication should include: Date of order: __________________________

Name/dose/route of medication: ____

Frequency/time of medication: ____

Does camper need assistance with administration of medication? Yes ____ No ____ If yes, please describe what type of assistance is needed: ____
____

Specific recommendations for administration (what type of symptoms would indicate need for administration of this medication): ____
____

List any special side effects, contra-indications and/or adverse reactions to be observed if the medication is administered: ____
____

List any adverse reactions that may occur to another child for whom this above medication is NOT prescribed, should he/she receive a dose of this medication: ____
____

This child has the knowledge and skills to safety possess and use the identified medication in a residential camp setting. As the child's physician, I give permission for this child to possess and use:

Epinephrine Auto-Injector ___________ Asthma Inhaler ___________

Physician's signature: ____ Date: _____

Physician's printed name: ____

Physician's address: ____

Physician's telephone number: _______________________________________

THIS SECTION TO BE READ AND SIGNED BY PARENT/LEGAL GUARDIAN
I hereby give permission for the above-named camper to keep the above-named medication in his/her possession while a camper and Camp Spaulding. I will also provide an extra Epi-Pen and/or emergency inhaler that will be kept at the Nurse's station for emergencies.

Parent/legal guardian signature: ____ Date: _________

Dear Campers,

The Camp Spaulding counselors are excited to meet you. We really enjoy getting to know the wonderfully unique aspects of each and every one of you, We have sent you this personal biography sheet for you and your parents to fill out. Please return this to CFS, P.O. Box 448, Manchester, NH 03105, with your camp application. Looking forward to seeing you!!

Camper Name: ________________________________ Nickname: _________________________

Age I will be at Camp: _______ This will be my ________ year at camp.

I want to go to camp because: ____

____

____

The activities I am most excited about are: ____

____

Something I really like about myself is: ____

____

I am proud of myself when: ____

____

At camp I think that I might have difficulty with: _______________________________________

____

The best way for my counselors to help me when I am upset or frustrated is to: ______________

____

I would also like my counselors to know: ____

____

Please circle the answer that describes you best:

1. I am generally a happy person	agree	disagree	don’t know
2. I make friends easily	agree	disagree	don’t know
3. When I compare myself to my friends I like who I am.	agree	disagree	don’t know

If you would like to make your camp deposit/payment by credit card, please complete the following information and return with the Camp Intake form, Summer Food Service application and your income verification.

Full name of person as appears on card:____

Full address to include street, town, state and zip:_____________________________________

____

Type of credit card (circle one): ❏ VISA ❏ MASTERCARD ❏ DISCOVER

Credit card number: ____

Expiration date: ____

Three digit security code (located on back of card after acct # - usually in italics) ___________

Amount to charge:_____________________________

Signature of cardholder: ____

Camper name(s): ____

Remove/cut this section prior to submitting credit card information

CAMP SPAULDING
Information / Photo Release

Child and Family Services often uses photos, artwork, stories and biographies of campers for its promotional, educational, fund-raising and counselor training efforts. On occasion, the news media publishes stories about Camp Spaulding, featuring camper likeness and/or opinions. Much of the cost of camp is supported by these efforts, which enables us to make camp affordable for local families. By signing this release, you will allow CFS to include your camper in our promotional/advancement efforts as described above.

I hereby authorize Child and Family Services to use photographs, artwork, words and/or select biographical information as described above.

Name of child:____

Name of parent or guardian:____

Signature of parent/guardian:____

Date:____

Address: ____

Phone: ____