



**BEAVER MEADOW AUDUBON CENTER**  
**1610 WELCH RD, N JAVA, NY 14113**  
**585-457-3228 or 800-377-1520**

**2015 SUMMER CAMP**  
**REGISTRATION & HEALTH FORM**

\*REGISTRATION & HEALTH FORMS NEED TO BE RETURNED **TOGETHER** WITH PAYMENT (CHECKS, CASH OR CREDIT CARD). REGISTRATIONS WILL NOT BE ACCEPTED OVER THE PHONE.

CHILD'S NAME: (PLEASE PRINT) \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

PARENT'S NAME: (PLEASE PRINT) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (CELL) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (WORK) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMAIL - \_\_\_\_\_

**SCHOLARSHIPS ARE AVAILABLE Provide a letter detailing why you need the scholarship. Letters must accompany registration form and are due by July 1st to be eligible for consideration.**

**Camp Levels GRADE JUST COMPLETED \_\_\_\_\_**

**FLEDGLINGS:** – Kindergarten & 1<sup>st</sup> Grade – 9-3 pm \$125 Member \$165 Non Member

\_\_\_\_ July 6 - 10  
**SONGBIRDS** – 1<sup>st</sup> - 3<sup>rd</sup> Grade – 9-3 pm \$125 Member \$165 Non Member

\_\_\_\_ July 13-17 OR \_\_\_\_\_ August 10-14  
**OSPREY** – 3<sup>rd</sup> - 5<sup>th</sup> Grade – 9-4 pm \$135 Member \$175 Non Member

\_\_\_\_ July 20 - 24  
**RAVENS** – 5<sup>th</sup> - 7<sup>th</sup> Grade – 9-4 pm \$135 Member \$175 Non Member

\_\_\_\_ July 27 – 31  
**RAPTORS** – 7<sup>th</sup> Grade to High School – 9-4 pm Member \$165 Non Member \$205

**\$35 FAMILY MEMBERSHIP** – If registering more than one child, you only need one membership per family \_\_\_\_ NEW \_\_\_\_ RENEWAL (Must be current at time of camp)

\_\_\_\_ **Can you help?** If you can spare an extra donation in any amount, we will add it to our scholarship fund & use it to assist another student.

**Make checks payable to Beaver Meadow Audubon Center (BMAC) TOTAL**

**A CAMP TEE SHIRT IS INCLUDED IN CAMP FEE**

Circle size :            **ADULT**            XL, L, M, S;    or **CHILD**    L, M, S

**I give permission to Buffalo Audubon Society to use photographs or videos taken of my child during camp, &/or samples of his/her writing or artwork in future promotional materials for the Center's programs.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Office use only:**

Date Paid \_\_\_\_\_ Payment Type \_\_\_\_\_ Sign in sheet \_\_\_\_\_ Computer \_\_\_\_\_ Master List \_\_\_\_\_

# BUFFALO AUDUBON SUMMER CAMP HEALTH FORM

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

PARENT / GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

STREET

CITY

ZIP

## IF YOU ARE UNAVAILABLE, PLEASE NOTIFY:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ALLERGIES: (FOOD, MEDICINE, INSECT BITES, PLANTS, LATEX, HYPER-SENSITIVITIES, ETC.)

DOES YOUR CHILD HAVE ANY ALLERGIES? NO YES - EXPLAIN \_\_\_\_\_

GENERAL INFORMATION: DOES YOUR CHILD SUFFER FROM:

\_\_\_ ASTHMA \_\_\_ DIABETES \_\_\_ HIGH BLOOD PRESSURE

\_\_\_ HEART TROUBLE \_\_\_ KIDNEY DISEASE \_\_\_ CONVULSIONS / SEIZURES

\_\_\_ HEMOPHILIA \_\_\_ CANCER/LEUKEMIA

EXPLAIN ANY POSITIVE RESPONSES: \_\_\_\_\_

LIST ANY PHYSICAL OR BEHAVIORAL CONDITIONS THAT MAY AFFECT OR LIMIT FULL PARTICIPATION IN CAMP:

**IMMUNIZATIONS: A CURRENT IMMUNIZATION RECORD FROM YOUR PHYSICIAN IS REQUIRED TO ATTEND CAMP. PLEASE ATTACH TO THIS FORM.**

## PERMISSION TO ADMINISTER MEDICATIONS

ACCORDING TO NYS HEALTH CODE, IF YOUR CHILD IS TO TAKE ANY PRESCRIPTION OR OVER-THE-COUNTER (OTC) MEDICATIONS WHILE AT CAMP, WE MUST HAVE AN ORDER SIGNED BY YOUR CHILD'S PHYSICIAN. THIS INCLUDES ADMINISTRATION OF OTC FOR EMERGENCY SITUATIONS SUCH AS BEE STINGS.

PRESCRIPTION MEDICATIONS THAT WILL BE TAKEN AT CAMP MUST BE PROVIDED IN THEIR ORIGINAL CONTAINERS, LABELED WITH THE CAMPER'S NAME.

\_\_\_ PRESCRIPTION MEDICATIONS \_\_\_ EPI-PENS \_\_\_ ORAL BENADRYL

\_\_\_ TOPICAL BENADRYL \_\_\_ NEOSPORIN (OR EQUIVALENT) \_\_\_ INSECT REPELLENT

\_\_\_ SUNSCREEN \_\_\_ OTHER \_\_\_\_\_

PERMISSION: I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT THE ADULTS LISTED ABOVE IN THE CASE OF AN EMERGENCY. IN THE EVENT NO ONE CAN BE REACH, I HEREBY GIVER PERMISSION TO THE PHYSICIAN SELECTED BY THE ADULT LEADER IN CHARGE TO SECURE PROPER TREATMENT.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_