

2010 Spartan Day Camp Application

Camper's Name: _____ Parent's Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ Development: _____

Home Phone: _____

Work Phone (Mr.): _____

Work Phone (Mrs.): _____

Emergency Contact & Number: _____

Grade during school year just completed: _____ Birth Date: _____

Age: _____ Male: Female:

Return Camper: New Camper:

Application should be returned with \$65 non-refundable deposit (\$50 for each additional camper) which will be applied to your child's final week's tuition to:

Tom DeMatteis, Director
Spartan Day Camp
Pike Creek Road
Wilmington, DE 19808

For Further information call Mr. DeMatteis at: 302.757.8750

CHECK OFF WEEKS OF EXPECTED ENROLLMENT:

(Must choose at least two consecutive weeks, but you may choose more)

	before care	after care
<input type="checkbox"/> June 14-18	_____	_____
<input type="checkbox"/> June 21-25	_____	_____
<input type="checkbox"/> June 28-July 2	_____	_____
<input type="checkbox"/> July 6-9*	_____	_____
<input type="checkbox"/> July 12-16	_____	_____
<input type="checkbox"/> July 19-23	_____	_____
<input type="checkbox"/> July 26 – July 30	_____	_____
<input type="checkbox"/> Aug 2-6	_____	_____

*(NO CAMP ON JULY 5th)

Transportation needed? Yes No

If transportation from place other than home please note.

Camper's Name: _____

The Division of Public Health for the State of Delaware does not require day campers to furnish a report of physical examination; however, a medical history including allergies, other health conditions, and current immunizations are required and must be kept on file at the camp. Please complete the following:

IMMUNIZATION HISTORY

(THIS IS A RECORD OF DATES OF BASIC IMMUNIZATIONS AND MOST RECENT BOOSTER DOSES.)

DTP SERIES _____ BOOSTER _____ BOOSTER _____
POLIO OPV _____ BOOSTER _____ TYPHOID _____
(SABIN)
MEASLES VACCINE (LIVE) _____ TUBERCULIN _____
GERMAN MEASLES _____ MUMPS VACCINE _____
(RUBELLA)
SMALLPOX _____ OTHER _____

HEALTH HISTORY

ALLERGIES DISEASES

HAY FEVER _____ CHICKEN POX _____
POISON IVY _____ MEASLES _____
INSECT STINGS _____ GERMAN MEASLES _____
PENICILLIN _____ MUMPS _____
OTHER DRUGS _____ ASTHMA _____

OPERATIONS OR SERIOUS INJUIRES (DATES) _____

CHRONIC OR RECURRING ILLNESS _____

OTHER DISEASES OR DETAILS OF ABOVE _____

ANY SPECIFIC ACTIVIES TO BE RESTRICTED _____

This health history is correct so far as I know, and the person herein described has my permission to engage in all camp activities, except as noted by me above.

I understand that part of the camping experience involves activities, group living arrangements and interactions that may be new to my child. These things come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free and so I have instructed my child on the importance of abiding by the camp's rules. My child and I both agree that he or she is familiar with these rules and will obey them.

In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the cap director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named on the reverse side.

SIGNATURE _____ DATE _____

Your signature below grants permission for your child to roller skate at Christina Roller Rink on scheduled days once a week. We have exclusive use of the rink on Tuesdays fro the younger children and Fridays for the older children. A fee of **\$3.00** is due the day of skating.

Also, the signature gives the camp permission to use any photo taken of your child while participating in camp activities in publications and on the camp website.

SIGNATURE _____ DATE _____