Camp Sunrise
2018 Camper Application

For youth 13 to 18 years old who live in Minneapolis or St. Paul

Please Print

Youth Name:_____
Last *First* *Middle*

Address:_____Youth's Phone: (_____)_____

City: _____, MN _____ Camper's Social Security Number: ***-**-_____
Zip *(Last four digits only required for time card)*

Date of Birth: _____ Gender: Male ☐ Female ☐

Optional - For statistical purposes, please indicate your ethnic or racial identity: _____

Have you attended a residential (overnight) camping program before? **YES** ☐ **NO** ☐

2018 Camp Sessions

Session 1: **Boys** Saturday, June 16 – Friday, June 22
Session 2: **Girls** Saturday, June 23 – Friday, June 29
Session 3: **Boys** Saturday, June 30 – Friday, July 6
Session 4: **Girls** Saturday, July 7 – Friday, July 13
Session 5: **Co-ed** Saturday, July 14 – Friday, July 20
Session 6: **Co-ed** Saturday, July 21 – Friday, July 27
Session 7: **Co-ed** Saturday, July 28 – *Thursday*, August 2

Session Information

- Space is limited and applicants may be placed on a waiting list.
- Sessions fill up quickly; please select more than one session.
- Waiting list campers will be notified one week prior to the session if space is available.

Registration

Which session is your 1st choice? _____
Which session is your 2nd choice? _____
Names of siblings or friends you want to go to camp with:

_____

_____

How did you find out about Camp Sunrise?
(Please check one)

☐ Minneapolis STEP UP ☐ St. Paul Right Track
☐ Team Teenworks
This summer I am working at:
_____
☐ I have attended Camp Sunrise before
☐ Other _____

Please return completed applications to:

YouthCARE / Camp Sunrise
2701 University Ave SE, Suite 205
Minneapolis, MN 55414

or Fax to:
612/338-6904

Questions? Visit us on the web at www.YouthCAREmn.org or call us at 612/338-1233

Please provide accurate and complete health information. **This health form is <u>required</u> and must be completed by a <u>parent or guardian.</u>**

Is the camper covered by any health insurance or Medical Assistance (MA)? ☐**YES** ☐**NO**

If YES- *Insurance provider*: _____ *Insurance Policy or MA Number:*_____

Name of Camper's Doctor: _____ Doctor's phone number: (_____)_____

Immunization Records:
Please provide current dates or attach a copy of an immunization record from your health care provider or the camper's school.

DIP (Diptheria, Tetanus, Pertussia) _____ MMR (Mumps, Measles, Rubella) _____ TD (Tetanus Booster) _____

HepB (Hepatitis B) _____ IVP/OPV (Polio) _____

Camper Health History
Circle any condition/s that apply to the camper:

ADD/ADHD
Asthma
Bedwetting
Behavior/Emotional
Diabetes
Drug / Alcohol Use
Frequent Earaches
Glasses/Contact Lense
Headaches
Hearing Aids
Hepatitis
Kidney/Heart Disease
Learning Disabilities
Menstrual Problems
Physical Limitations
Poor Eating Habits
Poor Sleeping Habits
Prosthesis/Adaptive Device
Seizures
Other (please explain)
None of the above

Does the camper have any allergies? **YES** ☐ **NO** ☐
(penicillin, bee stings, sulfa, foods, etc)

Does the camper have any dietary needs we should be aware of? **YES** ☐ **NO** ☐
We attempt to accommodate all dietary requests – advance notice of concerns is important in helping us meet the camper's needs.

Has the camper recently been exposed to a contagious disease? **YES** ☐ **NO** ☐

Does the camper have any restrictions around participating in physical activities? **YES** ☐ **NO** ☐
(Active activities at camp include, a 3 day canoe trip, hiking, field games, and carrying equipment)

If you circled any of the conditions listed above or answered yes to any of the questions, please explain: _____

_____

_____

_____

Is the camper taking any medications or using an inhaler that must be continued at camp? **YES** ☐ **NO** ☐
If YES, please ensure that the camper brings a 7-day supply of medications/inhalers.

Is the camper allowed to administer his/her own medication? **YES** ☐ **No** ☐ **Parent initials** _____

All medications prescription and over the counter will need to be kept in the camp office during the week of camp. Please be prepared to turn in any medications at the bus stop.

<u>Name of medication/inhaler & purpose</u>	<u>Prescription number</u>	<u>Pharmacy name & phone number</u>	
_____	_____	_____	(_____)_____
_____	_____	_____	(_____)_____
_____	_____	_____	(_____)_____

The staff at Camp Sunrise wants to provide your son or daughter with the best possible camp experience. Is there any additional behavioral, emotional, physical or medical information that the camp staff should know about your son or daughter?

_____

_____

Parent or Guardian Information

Name: _____ Relationship to camper: _____

Home phone: (____)_____ Cellular phone: (____)_____ Work phone: (____)_____

What is the best number to reach you at? Home ☐ Cellular ☐ Work ☐

Alternate Emergency Contact Information

It is important that we have contact information for another person we can call if the parent or guardian is not immediately available.

Name: _____ Relationship to camper: _____

Home phone: (_____)_____ Cellular phone: (_____)_____ Work phone: (_____)_____

Address: _____
Street *City* *State* *Zip Code*

Name: _____ Relationship to camper: _____

Home phone: (_____)_____ Cellular phone: (_____)_____ Work phone: (_____)_____

Address: _____
Street *City* *State* *Zip Code*

Permission

I give_____ (name of dependent) my permission to attend Camp Sunrise. I understand that travel by vehicle to and from Camp Sunrise in Rush City, MN and during the camp session will be necessary. I will arrange transportation for my dependent to get to and from the bus pick up and drop off location or I will contact the camp recruiter at 612/338-1233 to discuss transportation needs. I authorize appointed staff members to administer first aid and authorize medical treatment in my absence.

- I authorize YouthCARE staff and their representatives to administer first aid and medical treatment in my absence, and contact medical professionals, if necessary.
- I authorize my dependent to be transported by bus, van or personal vehicle driven by YouthCARE staff and its representatives.
- I release YouthCARE of all liability of injury, death, or other damages to me, my child, family, estate, heirs, or assigns that may result from his/her participation in the program, including but not limited to transportation, and hold harmless any YouthCARE staff or its representatives.
- I understand personal information on this form and other information collected during program participation will be kept confidential and may be used in evaluating and researching YouthCARE's programs.

Photo & Video Release: Youth participants may be photographed and/or videotaped by YouthCARE or other organizations approved by YouthCARE. This photo release gives YouthCARE and/or its approved partner's permission to photograph and/or videotape your child and release said photos or videos for publication. If you do not agree to these terms please check the no box below.

☐ **NO -** I do not wish to have photos or video footage of my child appear in publications.

_____

Signature of Parent / Guardian **Date**

For further information about YouthCARE or this form, please visit our website at www.YouthCAREmn.org or contact a staff member at 612/338-1233.

Summer Food Service Program Household Income Statement YouthCARE

Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http:// www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.

Step 1 **List all infants, children, and students through grade 12 in the household, even if they are not related.** Attach an additional page if necessary.

First Name	Last Name	Age	**Foster Child?** (An agency or court has legal responsibility for the child.) If yes, fill in the circle.	- Optional - Ethnicity	- Optional – Racial Identity Fill in one or more circles for each child.				
				Is the child Hispanic / Latino? If yes, fill in the circle.	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○

Step 2 **Do any Household Members, including yourself, currently participate in any of these assistance programs: SNAP, MFIP or FDPIR?** Circle one: **Yes** **No**

Medical Assistance and WIC payments do not qualify. If **No** > Go to STEP 3. If **Yes** > Write the **CASE NUMBER** here: then go ____ to STEP 4.

Step 3 **A. List ALL Adult Household Members including yourself and report all incomes.** Attach an additional page if necessary. (Skip STEP 3 if you answered Yes to STEP 2 or if all participants are foster children.)

Adults - Full Name For the purpose of this program, the members of your household are "Anyone who is living with you and shares income and expenses, even if not related." Include any college students temporarily away from home. List the full name of each household member not listed in Step 1 and their income(s) in whole dollars. If a person has no income, write in 0 or leave the section blank. This is your certification (promise) that there is no income to report.	**Gross Pay from Work** *Do not write in an hourly wage.*					**Farm or Self-Employment**	**Public Assistance, Child Support, Alimony**					**All Other Incomes**				
	Gross pay before deductions (Not take-home pay).	Weekly	Bi-Weekly	2x Month	Monthly	Net Income after business expenses. State if annual or monthly.	Payments received.	Weekly	Bi-Weekly	2x Month	Monthly	Pension, retirement, disability, unemployment, Veterans benefits, etc.	Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	$	○	○	○	○	$	○	○	○	○

B. Last four digits of signer's Social Security Number or no SSN (required):

X X X – X X – [ ][ ][ ][ ] Or ☐ I don't have a Social Security Number.

C. Do any of the children listed in Step 1 receive regular incomes such as SSI or wages?

TOTAL regular incomes of children, if any: $ ____ Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly ○

Step 4 I certify (promise) that all information on this application is true and correct and all household members and incomes are reported. I understand that I am applying for federal benefits in the form of free program meals and that program officials may verify the information on the application and that purposely providing untrue or misleading statements may result in prosecution under state or federal criminal laws.

Signature of Adult Household Member (required) _____ **Print Name:** _____ **Date:** _____

Sponsor Use Only Approved: ☐ Foster ☐ Case Number ☐ Income Total Household Members: _____ Total Income: $_____ per ____

Denied: ☐ Incomplete application ☐ Income exceeds guidelines ☐ Other _____

Sponsor Signature: _____ Date: _____