



Camp Sunrise 2017 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 _____ Zip _____ Camper's Social Security Number: ***-**-_____
(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**

2017 Camp Sessions

- Session 1: **Boys** Saturday, June 17 – Friday, June 23
- Session 2: **Girls** Saturday, June 24 – Friday, June 30
- Session 3: **Boys** Saturday, July 1 – Friday, July 7
- Session 4: **Girls** Saturday, July 8 – Friday, July 14
- Session 5: **Boys** Saturday, July 15 – Friday, July 21
- Session 6: **Boys** Saturday, July 22 – Friday, July 28
- Session 7: **Girls** Saturday, July 29 – Friday, August 4
- Session 8: **Girls** Saturday, August 5 – Friday, August 11
- Session 9: **Co-ed** Saturday, August 12 - Thursday, August 17

2 Week veteran camper program for alumni campers
 Boys weeks 5-6
 Girls weeks 7-8

Session Information

- Space is limited and applicants may be placed on a waiting list.
- Sessions fill up quickly; please select more than one session.
- Sessions 1-2 are open to youth 13 to 16 years old.
- Sessions 3-9 are open to youth 14 to 18 years old.
- 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

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

Is the camper covered by any health insurance or Medical Assistance (MA)?	YES	NO
<p>If YES- Insurance provider: _____ Insurance Policy or MA Number: _____</p> <p>Name of Camper's Doctor: _____ Doctor's phone number: (_____) _____</p>		

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 (Diphtheria, 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:		Does the camper have any allergies? (penicillin, bee stings, sulfa, foods, etc)	YES NO
ADD/ADHD	Kidney/Heart Disease	Does the camper have any dietary needs we should be aware of? We attempt to accommodate all dietary requests – advance notice of concerns is important in helping us meet the camper's needs.	YES NO
Asthma	Learning Disabilities	Has the camper recently been exposed to a contagious disease?	YES NO
Bedwetting	Menstrual Problems		
Behavior/Emotional	Physical Limitations	Does the camper have any restrictions around participating in physical activities? (Active activities at camp include, a 3 day canoe trip, hiking, field games, and carrying equipment)	YES NO
Diabetes	Poor Eating Habits		
Drug / Alcohol Use	Poor Sleeping Habits		
Frequent Earaches	Prosthesis/Adaptive Device		
Glasses/Contact Lense	Seizures		
Headaches	Other (please explain)		
Hearing Aids	None of the above		
Hepatitis			
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 _____
<i>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.</i>		
<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

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
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Step 2 Do any Household Members, including yourself, currently participate in any of these assistance programs: SNAP, MFIP or FDIPIR? 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 <i>Do not write in an hourly wage.</i>					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
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

 - 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: _____