



WHAT IS YOUR CHILD'S MAJOR DISABILITY (please be specific)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CAN YOUR CHILD TOLERATE BEING OUTDOORS MORE THAN 2 HOURS AT A TIME?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain. \_\_\_\_\_

EATING HABITS: Eats by self \_\_\_\_\_ Yes \_\_\_\_\_ No  
Needs assistance \_\_\_\_\_ Yes \_\_\_\_\_ No  
Regular diet \_\_\_\_\_ Yes \_\_\_\_\_ No  
Special diet \_\_\_\_\_ Yes \_\_\_\_\_ No

Please specify any special dietary needs or eating habits we should be aware of:  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY MEDICATION THAT YOUR CHILD TAKES.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If medication is to be taken by a child, prescription or non-prescription, the medication presented to camp personnel **must** remain in the original container and **must** state:

**Written administration instructions, signed and dated by the parent must include:**

- a. camper's name
- b. prescription name and/or number
- c. name of prescribing physician
- d. condition for which medication is prescribed
- e. quantity of dose to be given
- f. date(s) and time(s) of administration
- g. any other considerations related to the medication or illness

**The Camp staff will record the following:**

- a. signature when receiving medication and form
- b. dosage given
- c. note the time and date administered
- d. initials of the administering staff on the medical form

DOES HE/SHE HAVE A WHEELCHAIR? \_\_\_\_\_ NEED A SPECIAL LIFT? \_\_\_\_\_

DOES HE/SHE WEAR A BRACE? \_\_\_\_\_

If yes, how long should the brace be worn? \_\_\_\_\_

**PLEASE CHECK & EXPLAIN ALL THAT APPLY:**

Headaches \_\_\_\_\_ Asthma \_\_\_\_\_  
Indigestion \_\_\_\_\_ Hysteria \_\_\_\_\_  
Epileptic Seizures \_\_\_\_\_ Hay Fever \_\_\_\_\_  
Sinus Infection \_\_\_\_\_ Cramps \_\_\_\_\_  
Other Problems \_\_\_\_\_ Fainting \_\_\_\_\_

PLEASE NOTE ANYTHING THAT YOU FEEL MAY HELP US TO BETTER UNDERSTAND YOUR CHILD: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IS YOUR CHILD ALLERGIC TO ANY FOOD OR DRINK? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list: \_\_\_\_\_

DOES YOUR CHILD HAVE ANY OTHER ALLERGIES? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list: \_\_\_\_\_

PLEASE LIST ANY DRUGS, LIKE PENICILLIN, TO WHICH YOUR CHILD HAS A SENSITIVITY.  
\_\_\_\_\_  
\_\_\_\_\_

HAS YOUR CHILD HAD THE FOLLOWING INNOCULATIONS?

Typhoid \_\_\_\_\_ Yes \_\_\_\_\_ No Give Date \_\_\_\_\_

Diphtheria \_\_\_\_\_ Yes \_\_\_\_\_ No Give Date \_\_\_\_\_

Smallpox \_\_\_\_\_ Yes \_\_\_\_\_ No Give Date \_\_\_\_\_

Tetanus \_\_\_\_\_ Yes \_\_\_\_\_ No Give Date \_\_\_\_\_

HAS YOUR CHILD HAD ANY RECENT RESPIRATORY AILMENTS (colds, flu, bronchitis, pneumonia, asthma, etc.)? Please specify:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY OTHER PROBLEMS (medical, social, etc.) THAT WOULD HELP US TO LEARN MORE ABOUT YOUR CHILD: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW DID YOU HEAR ABOUT CAMP TIGER? \_\_\_\_\_

NAME OF FAMILY PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

HOW MANY TIMES HAS YOUR CHILD ATTENDED CAMP TIGER? \_\_\_\_\_

\* Due to the high number of applicants, priority will be given to the first-time campers and old campers who have attended for only one year. Campers who have attended for more than one year will be given priority on a first come, first serve basis. Priority will be given to Louisiana residents and to children ages 7-12.

**REMEMBER THAT THE COMPLETE APPLICATION IS DUE FRIDAY, APRIL 17, 2009 TO THE ADDRESS LISTED AT THE TOP OF THE FIRST PAGE. AFTER EVALUATING ALL OF THE APPLICATIONS, WE WILL SEND YOU A LETTER CONFIRMING YOUR CHILD'S PLACE IN CAMP TIGER 2009 AS WELL AS SOME ADDITIONAL INFORMATION ABOUT CAMP. THIS ADDITIONAL INFORMATION INCLUDES FORMS THAT MUST BE COMPLETED AND RETURNED BEFORE THE START OF CAMP.**

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