



# Camp La Verne

## 2008 Summer Camps

**Junior Camp**  
(Grades 3-5)  
July 27<sup>th</sup> – Aug. 2<sup>nd</sup>  
Janet Hart, Director

**Junior High Camp**  
(Grades 6-8)  
August 3<sup>rd</sup> - 9<sup>th</sup>  
Ron Hart & Jeff  
Pence, Directors

**Senior High Camp**  
(Grades 9-12)  
August 10<sup>th</sup>- 16<sup>th</sup>  
Director TBD

(Check one)

**Camp Sign-In: 4:00p.m. Sunday**  
**Camp Ends: 11:00a.m. Saturday**

**Fees: \$225 if postmarked by July 12<sup>th</sup>**  
**\$300.00 thereafter.**

**Scholarships are available!**

**Everyone must pre-register!**  
**NO ONSITE REGISTRATIONS!**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/ State/ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cabin mate preference \_\_\_\_\_

Any special needs?  
(health, food, etc) \_\_\_\_\_

Church I Attend  
(if applicable) \_\_\_\_\_

Amount enclosed

Please make checks payable to:  
Camp La Verne, Inc.  
P.O. Box 355  
La Verne, CA 91750-0355

\$ \_\_\_\_\_

- A WARM SLEEPING BAG
- Pillow
- Waterproof boots or hiking boots
- 4-5 pair of WARM socks
- Shoes for inside
- Hat, coat, gloves
- Towel & Washcloth
- Toothbrush & paste
- Flashlight
- A favorite game
- A favorite story
- A friend (they must pre-register)
- **No electronics, No candy**

### Parental Consent Form:

I / We, the undersigned parent / guardian of \_\_\_\_\_ a minor, do hereby authorize leadership of Camp La Verne as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the medical practice act on the staff of a licensed hospital, whether such diagnosis or treatment is required at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on part of aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the civil code of California and shall remain in effect from \_\_\_\_\_ until \_\_\_\_\_ or unless revoked in writing and delivered to said agents.

I permit the use of my child's image in the Promotion of Camp La Verne

I authorize my child to leave camp with: \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

#### What to bring

Print Parent / Guardian Name \_\_\_\_\_

#### Important Contact Information

Linda Costello, Manager (909) 524-8581  
Pete Harrington, Manager (909) 524-8438  
Paul Wilkinson, Registrar (909) 392-4079  
Camp La Verne (On-Site) (909) 794-2931  
Or visit [www.camplaverne.org](http://www.camplaverne.org)



**Camper Health History and Medical Consent Form**

Camp Attending: \_\_\_\_\_ Dates Attending: \_\_\_\_\_

Camper's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age at Camp: \_\_\_\_\_ Sex (circle one): M / F Height: \_\_\_\_\_ Wt: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_/\_\_\_/\_\_\_

*Please list any conditions (allergies, headaches, heart, respiratory, sinus behavioral, etc.), or limitations that may affect the camper's participation in camp activities.*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Please list any medications the camper will be taking while at camp.*

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

**Consent for Non-prescription Medication:** During the above listed dates, I give my permission for my child to receive the following over the counter medications from the assigned medical staff worker. (Please Circle)

Kaopectate	YES	NO	Pepto-Bismol	YES	NO
Caladryl	YES	NO	Milk of Magnesia	YES	NO
Tylenol	YES	NO	Chloraseptic Spray	YES	NO
Advil	YES	NO	Cepacol	YES	NO
Benadryl	YES	NO	Alka Seltzer/Rolaids	YES	NO

**In case of emergency notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Person to be notified if above cannot be reached:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Consent and for medical treatment:**

I hereby give permission to the medical personnel selected by Camp La Verne to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in a emergency, I hereby give permission to the physician selected by Camp La Verne to secure and administer treatment, including hospitalization, for the child named above. This form may be photocopied for trips out of camp.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent or legal guardian if camper is under 18 years of age.