



Spina Bifida of Greater New Orleans

Serving all of Louisiana

504 737 5181

Post Office Box 1346, Kenner, Louisiana 70063

Email: [sbgn.org](mailto:sbgno@sbgn.org) Web site: www.sbgno.org

SIBLING PROGRAM

JULY 26 & JULY 28, 2011

APPLICATIONS SHOULD BE MAILED

TO THE ADDRESS ABOVE BY JUNE 30th TO RESERVE A SLOT.

PERSONAL INFORMATION - To be filled out by parent/guardian.

Child's Name _____ DOB: _____

Address _____ City _____ State _____ Zip _____

Sex _____ Telephone-Home: _____ Work: _____ Cell: _____

E-Mail Address _____ T-shirt size _____

School Applicant Attends _____ Religion _____

Personality: What kind of person is he/she? Easy-going, calm, restless, sensitive, alert, cheerful, strong-willed, shy, moody. _____

Physical Picture: Please note any special problems that might affect camper at Camp _____

Eating Habits _____

Does He/She Take Any Medication? If So, What Kind? _____

Will the Applicant Take Medication at Camp? _____ At What Time? _____

Are the applicant's immunizations current? _____

Does the applicant have sensitivity to penicillin or any other drugs? _____ Please list:

Does the applicant have: headaches? _____ Asthma? _____ Seizures?: _____ Food or other

Allergies? _____ Please list _____

Please list any other medical problems: _____

Name of Physician _____ Telephone Number _____

Emergency Contact-Name: _____ Phone: _____

Parent's/Guardian's Authorization

This health history is correct so far as I know, and I, _____ give my full consent for the applicant _____ to attend Spina Bifida of Greater New Orleans Summer Sibling Program and to engage in all prescribed camp activities, except as noted by me.

In consideration of participation in the program and for the general purposes of the camp specifically including, but not limited to, the community service afforded by the availability of the program to children with disabilities, I agree to indemnify and hold harmless SBGNO from and against any injury or loss which my child may suffer arising out of or related to the following:

1. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above;
2. The administration of physician prescribed medication. Prescribed medication will be administered ONLY if the medication is in its original container labeled with the physician's instructions for its use accompanied by a written statement by the child's parent or guardian as to the time of day the specific (please state name of) medication is to be given;
3. Travel to and from camp and during the camp day in transportation vehicles provided by SBGNO; and
4. Camp activities, including but not limited to swimming and fieldtrips. Children are not allowed to swim if they have a communicable disease, open sore or infection. Please advise the camp director of your child's current medical condition during the camp week. The camp director and/or camp staff will make the final determination whether a child may swim or otherwise participate in activities.

In addition, permission is granted to SBGNO to photograph, videotape or record my child _____ for the purpose of the media or for SBGNO publications.

Signature _____

Date _____