

Oak Hill Day Camp Application for Enrollment*

phone (615) 298-9583 • fax (615) 298-9565 • rec.fpcnashville.org

Mail to: First Presbyterian Church • Oak Hill Day Camp • 4815 Franklin Pike • Nashville, TN 37220 • Only one camper per application.
Hours: 8:45 A.M.–3:00/5:00 P.M. • Early Care: 7:30 A.M. (free) • rec.fpcnashville.org • Children picked up past 5:30 P.M. charged \$2/minute

Oak Hill Day Camp

4 years (by May 1, 2018) - Rising 5th

- Until 3:00 P.M. \$300/week
- Until 5:00 P.M. \$345/week
 - June 4-8
 - June 11-15
 - June 18-22
 - June 25-29
 - July 2-6 (no camp July 4)
 - July 9-13
 - July 16-20
 - July 23-27
 - July 30-Aug 3

Middle School Camp

Rising 6th - Rising 8th
Until 5:00 P.M. \$350/week

- June 4-8
- June 11-15
- June 18-22
- June 25-29
- July 2-6 (no camp July 4)
- July 9-13
- July 16-20
- July 23-27
- July 30-Aug 3

Horse Camp

Rising 1st - Rising 6th
Until 3:00 P.M.

- \$100/day if not enrolled in camp that week
- \$70/day if enrolled in camp that week
 - June 8
 - June 15
 - June 22
 - June 29
 - July 6
 - July 13
 - July 20
 - July 27
 - August 3

Basketball

Rising 1st - Rising 6th

- Until 3:00 P.M. \$250/week
- Until 5:00 P.M. \$295/week
 - June 4-8

Soccer

Rising 1st - Rising 6th

- Until 3:00 P.M. \$250/week
- Until 5:00 P.M. \$295/week
 - June 11-15

Theatre Camp

Rising 1st - Rising 8th

- Until 3:00 P.M. \$500
- Until 5:00 P.M. \$590
 - June 11-15, 18-22

GAP Camp

4 yrs - Rising 8th grade

- \$60/day until 3:00 P.M.
- \$75/day until 5:00 P.M.
 - May 29
 - May 30
 - May 31
 - June 1
 - August 6
 - August 7
 - August 8
 - August 9
 - August 10

Name of Camper: _____ Name Used: _____

Birthdate: _____ Age: _____ Grade (2018): _____ Gender: _____

Camper Home Address: _____
STREET ADDRESS CITY STATE ZIP

Shirt Size: _____ \$5 for extra shirt for tie-dye day!

PARENT(S)/GUARDIAN WITH LEGAL CUSTODY TO CONTACT IN CASE OF EMERGENCY OR BILLING PURPOSES:

Name: _____ Relationship to Camper: _____

Preferred Phones: (_____) _____ (_____) _____ E-mail: _____

Home Address: _____
(IF DIFFERENT FROM ABOVE) STREET ADDRESS CITY STATE ZIP

SECOND PARENT/GUARDIAN WITH LEGAL CUSTODY TO CONTACT IN CASE OF EMERGENCY OR BILLING PURPOSES:

Name: _____ Relationship to Camper: _____

Preferred Phones: (_____) _____ (_____) _____ E-mail: _____

I approve this application and the conditions listed below. I have written any necessary and pertinent information concerning our family and our camper. In case of illness, I hereby give permission for medical care by physician and/or hospital chosen by Camp Director. I understand that every effort will be made to contact parents/guardians in case of emergency. If a child's behavior or limitations poses a threat to themselves or other children/staff, we reserve the right to make a determination if the child should continue to participate in the program. No alcohol, drugs, weapons, personal sports equipment or animals allowed on the property.

Insurance Carrier: _____ Policy Number: _____

Signature of Parent/Guardian: _____ Date: _____

OHDC has my permission to apply sunscreen to my child. YES NO

I give permission to use my child's photo on OHDC marketing materials and website. YES NO

I give permission to receive communications by email. YES NO

I am enclosing a tax deductible contribution to Oak Hill Day Camp. \$_____.

Each camper may request one friend to be in his/her group. Must be same grade/age: _____

***CONDITIONS OF APPLICATION:** Please make check(s) payable to First Presbyterian Church. All deposits per session must accompany each application and are non-refundable. Signature above and on the Health History form **MUST BE COMPLETED** in full, including shot records, before child will be considered registered for camp. Faxed shot records from the doctor's office are acceptable. Balance is due on or before May 18, 2018. Deposit will be refunded in-full at end of camp if your child remains on the waiting list.

Oak Hill Day Camp Health History

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Only one camper per form. Forms available online at rec.fpcnashville.org

This form is to be filled out by the parent/guardian. You do not need a camp physical.

This information is gathered only to assist in identifying appropriate care.

Name: _____ Name Used: _____

School Attended: _____ Birthdate: _____

Teacher we may call for reference: _____ Phone: _____

Does your child have an IEP in his/her school? _____ Does your child have a behavioral plan in his/her school? _____

DATE OF IMMUNIZATIONS (or booster dates):

(No child will be allowed to attend camp until immunization dates are submitted to Oak Hill Day Camp.)

_____ Tetanus (or DPT or TD) _____ Oral Polio (Sabin) _____ Measles
_____ Injectable Polio (Salk) _____ Mumps _____ Hoemophilus
_____ Hepatitis B _____ Tuberculin test given (most recent) _____ Other

Pediatrician/Doctor's Name: _____ Phone: _____

Applicant under physician's care for the following condition(s): _____

Current medications and treatments: _____

Any medically prescribed dietary restrictions: _____

Any allergies (food, drugs, plants, insects, etc.): _____

Any physical limitations on activities: _____

Operations or serious injuries (include dates): _____

Chronic, recurring illness, medical condition or emotional or behavioral difficulties: _____

Give approximate dates of the following (if any): _____

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Ivy Poisoning, etc. | <input type="checkbox"/> Insect Sting Reaction | <input type="checkbox"/> Penicillin Reaction | <input type="checkbox"/> Other Drug Allergy |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sight Impairment | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Autism | <input type="checkbox"/> Rescue Inhaler |
| <input type="checkbox"/> Other (specify): _____ | | | |

Any additional health information: _____

IMPORTANT: This box must be completed for attendance.
This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.
Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp Director 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 an emergency. I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. By signing this form, I am releasing FPC and all of its employees and volunteers from any liability as a direct or indirect result of the program.
Signature of Parent or Guardian: X _____ Date: _____