

**2017 The New School's Discovery Day Camp in Thornden Park**

Mail to: Miranda Hine

301 Clarendon Street, Syracuse, NY 13210

(315) 478-5164

Registration Fee: \$160 payable to The New School

**Participant Registration and Information Form**

**Dates of Attendance (please circle): Camp 4, August 7; Camp 5: August 28**

Name of Participant \_\_\_\_\_  
Name of Parent(s) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_ day (\_\_\_\_) \_\_\_\_\_ evening  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  Male  Female Entering Grade: \_\_\_\_\_  
E-mail \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_

<p><b>Emergency Contact</b> Name _____ Relationship to Participant _____ Address _____ City, State, Zip _____ Phone Number (____) _____ day (____) _____ evening</p>
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<p><b>Health Insurance Information</b> Name of Policy Holder _____ Name of Carrier _____ Policy Number _____</p>
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**Please describe below the abilities, limitations and/or needs of the participant in the following categories:**

Physical/Motor Skills \_\_\_\_\_

Emotional/Social Needs \_\_\_\_\_

**Medical History of Participant**

**Please answer these questions thoroughly and completely. People with a variety of medical difficulties can successfully complete these programs, but for your safety and the safety of others, we must have this information on file.**

Please circle **Y** (yes) or **N** (no) next to each of the statements to indicate whether you have had or are currently experiencing the problems mentioned. Give specific details about **Y** answers at the bottom.

Y N Any problems with vision or hearing – requires glasses or hearing aid	Y N Dizzy spells, fainting, convulsions, persistent headaches
Y N Motion Sickness	Y N Chronic cough, bronchitis, bloody sputum
Y N Shortness of breath or asthma on exertion	Y N Chest pains on exertion or deep breathing
Y N Palpitation of the heart, irregular heart beat, heart murmurs or poor circulation	Y N Low or high blood pressure
Y N Frequent nausea or vomiting, food intolerances, heartburn	Y N Frequent diarrhea or blood in stools
Y N Frequent abdominal cramps or severe menstrual cramps	Y N Hernia
Y N Difficulty urinating, burning or pain on urination, frequent urination	Y N Kidney infection or stones
Y N Chronic pain in neck, back, shoulders, arms or legs	Y N Broken bones, joint dislocation, serious sprains, weakness of muscles
Y N Back, knee, ankle or other muscular-skeletal injuries	Y N Joint pain, swelling or stiffness without injury
Y N Any severe injury to head, chest or internal organs	Y N Severe illness requiring hospitalization or prolonged incapacitation
Y N Chronic skin problems (rash, infection)	Y N Allergy to medicines, bee stings, insect bites, foods, etc.
Y N Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, or heights)	Y N Continuing use of alcohol, drugs or medicines
Y N Episodes of depression, anxiety, hysteria or nervousness	Y N History of diabetes, thyroid trouble, bleeding problems
Y N Special dietary restrictions (vegetarian, vegan, macrobiotic, etc.)	Y N Are you now or have you ever been under the care of a psychologist or psychiatrist?
Y N Currently on any medications (if so, please list below)	

If you checked 'Yes' on any of the items above, please list details below according to item number. Be specific (include dates, names of medications, history of condition, treatment, etc.). Use additional sheet of paper if necessary.

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There will be no refunds of registration fees once paid

I hereby affirm that I have answered the above to the best of my knowledge. I understand that I am responsible for any misrepresentations of this information that may lead to injury and illness and/or expulsion from this program. I also understand that my health insurance must be current and valid before beginning this program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I give permission for pictures of my child to be used in future publications or press releases.

Signature \_\_\_\_\_ Date \_\_\_\_\_