TLC CAMP CAMPER APPLICATION

SIBLING

Please fill out all pages of the application COMPLETELY and PRINT CLEARLY

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M / F / / \_

First MI Last DOB (Mo/Day/Yr)

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State/Zip Code

Telephone: ( ) ( ) .

Primary Number Alternative Number

Shirt Size (circle one): **Child S M L Adult S M L XL XXL**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Circle One: **Mother Father Guardian Printed Name**

**Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Hospital/Clinic**

How did you hear about TLC Camp? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use this checklist to ensure that all forms listed below are completed and signed by parent/guardian and doctor and have returned by **May 15.**

* \_\_\_\_\_ **Application** with parent/guardian printed name and signature
* \_\_\_\_\_ **Physical Examination** completed and signed by physician
* \_\_\_\_\_ **Medical Consent** signed by parent/guardian
* \_\_\_\_\_ **Medical History** of cancer patient and sibling (completed even if child’s treatment is over)
* \_\_\_\_\_ **Port-a-Cath/Broviac/Central Line Catheter** completed and signed by physician
  + - Reviewed and initialed by parent/guardian
* \_\_\_\_\_ **Waiver** signed by parent/guardian

If any of the above is returned to us incomplete, they will be returned to you for completion and the application will not be processed until all information is received.

Lombard Junior Women’s Club – P.O. Box 512 – Lombard, IL 60148

[www.lombardjrs.com/tlc-camp-inc](http://www.lombardjrs.com/tlc-camp-inc)

TLC CAMP MEDICAL CONSENT

For all campers and siblings

**To be completed by the Parent/Guardian and returned with application.**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M / F / / \_

First MI Last DOB (Mo/Day/Yr)

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Diagnosis Date diagnosis was first made

Parent/Guardian Mother Father Guardian

Parent/Guardian Mother Father Guardian

Telephone: ( ) ( ) ( ) .

Primary Mom Cell Dad Cell

Telephone: ( ) ( ) ( ) .

Alternate Mom Work Dad Work

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child lives with: \_\_\_\_\_Mother \_\_\_\_\_Father \_\_\_\_\_Guardian

If parents are divorced, which parent has legal custody? \_\_\_\_\_Mother \_\_\_\_\_Father \_\_\_\_\_Guardian

Person other than parent/guardian to contact in case of an emergency and parent/guardian cannot be reached:

Other contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

Hematologist/Oncologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) | Emergency Phone: ( ) |

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) | Emergency Phone: ( ) |

**MEDICAL TREATMENT CONSENT INFORMATION:** To be used by medical staff and/or emergency room personnel.

I hereby grant permission for the medical staff to administer routine care, medications, and determine need for lab/x-ray studies for my child, as well as any emergency care required.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: **YES NO**

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One: **Mother Father Guardian**

TLC CAMP MEDICAL HISTORY

For all campers and siblings

**To be completed by the Parent/Guardian and returned with application.**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M / F / / \_

First MI Last DOB (Mo/Day/Yr)

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Diagnosis Date diagnosis was first made

Hospital/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child no longer takes chemotherapy or radiation, when was treatment ended? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle as it pertains to your child:**

1. Has a port-a-cath Yes No 10. Has a problem with bedwetting Yes No
2. Has a Broviac/central line catheter Yes No 11. Has behavioral problems Yes No
3. Has VP shunt or Ommaya Reservoir Yes No 12. Uses crutches (if yes, send with child) Yes No
4. Has had an amputation Yes No 13. Uses a wheelchair (if yes, send with child) Yes No
5. Has had a limb salvage procedure Yes No 14. Has had a seizure in the last 3 years Yes No
6. Has had a transplant \_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No 15. Cancer or leukemia has relapsed Yes No
7. Problem with hearing/wears hearing aid Yes No 16. Has Asthma Yes No
8. Child is legally blind Yes No 17. Has Diabetes Mellitus Yes No
9. Wears glasses or contact lens Yes No 18. Has Diabetes Insipidus Yes No

If you answered YES to any of the above, please explain:

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

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Any additional medical problems, please explain:

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Does your child need any assistance with activities of daily living (dressing, toileting, etc.)? Yes No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any food restrictions:

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Please list and describe any operations your child has had and the approximate date:

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

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Please list and describe any serious illnesses or procedures your child has had in the past two years:

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

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Please list any physical restrictions or limitations to activity (i.e. no contact sports, rough activity, swimming, ear plugs, etc.)

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MEDICATION FORM

**Application will NOT be processed without this form**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / / \_

First MI Last DOB (Mo/Day/Yr)

List all medications to be taken at camp:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Date at Camp** | **Time at Camp** |
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Will the child be responsible for administering medication? **Yes No**

When sending medication to camp, send only the amount to be administered. Place medication in a zip-lock plastic bag that is labeled with the person’s name, the name of the medication, the dosage of each pill, the dosage to be administered and the date/time the medication should be administered.

**PLEASE BE VERY SPECIFIC**

**Example of what to write on zip-lock bag:**

Camper: Jane Doe

Medication: Prednisone (2mg. Tablets)

On Monday give 2 tablets (4mg.) of Prednisone at noon with lunch. She also takes it with milk.

**MEDICATIONS:**

It is expected that each family will supply ALL of their child’s routine medications including anti-nausea drugs, dressing materials, Broviac flushing supplies needed. Unless indicated otherwise below, the medical staff will store and dispense these medications to your child and will maintain a full supply of emergency medications. Please send appropriate extra oral medication in case a dose is not kept down or needs to be repeated. In order to allow your child to participate in and enjoy the program activities as much as possible, whenever appropriate, the scheduling of IV chemotherapy and blood work, other than routine counts, may be re-scheduled by your child’s physician during the camp session.

Because of the nature of camp activities, it is required that the medical staff supervises medication for all campers. Campers will be allowed to keep “as needed medications” when appropriate. Parents should discuss special needs of your child at camp check-in.

Please indicate any further information about your child’s medical needs that you feel the medical care team and your child’s Senior Counselor should know:

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

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Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One: **Mother Father Guardian**

TLC CAMP MEDICAL HISTORY

For all campers and siblings

**To be completed by the PHYSICIAN/NURSE PRACTIONER and returned with application.**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / / \_

First MI Last Exam Date

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

Hem/Onc Diagnosis B/P Height | Weight

Date diagnosis first made: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently on therapy for cancer? **Yes No**

**\_\_\_\_\_** General exam, normal

\_\_\_\_\_ Abnormal findings, please specify:

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

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\_\_\_\_ NONE

\_\_\_\_ Active and/or recent medical issues, please specify:

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\_\_\_\_ NONE

Allergies:

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Laboratory Values (if indicated) \_\_\_\_\_\_\_\_ N/A

Normal Abnormal Comment

CBC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemistries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent Tetanus immunization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Chicken Pox/Varicella Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID-19 Vaccination (Shot 1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID-19 Vaccination (Shot 2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID-19 Vaccination (Shot Booster): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID-19 Vaccination Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lombard Junior Women’s Club – P.O. Box 512 – Lombard, IL 60148

[www.lombardjrs.com/tlc-camp-inc](http://www.lombardjrs.com/tlc-camp-inc)

MEDICATION FORM

**Application will NOT be processed without this form**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / / \_

First MI Last DOB (Mo/Day/Yr)

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| --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** |
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On the basis of this examination of this day, I approve this child’s participation in the TLC CAMP day camp:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ With no limitations

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ With the following limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician/Nurse Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sponsored by the Lombard Junior Women’s Club**

**Waiver and Consent Form**

Please read this form carefully. Be aware that by signing to participate in the above program, you will be waiving and releasing all claims for injuries you might sustain arising out of the above program.

I understand that the TLC Camp, Inc. program will include not only normal activities conducted on the campgrounds but also certain field trips and other activities outside the campgrounds, which will require transportation to and from these locations. I recognize and acknowledge that there are certain risks of physical injury to participants in the above program and I agree to assume the full risk of any such injuries, damages, or loss, regardless of severity, which I or my child may sustain as a result of participating in any activities connected or associated with any such program.

I waive and relinquish all claims I may have against the Lombard Park District, the Lombard Junior Women’s Club and their officers or agents, servants, employees, volunteers, and medical staff as a result of participating in above program. I hereby fully release and discharge the Lombard Park District, the Lombard Junior Women’s Club and all of their officers or agents, servants, employees, volunteers, and medical staff from any and all claims from injuries, damage, or loss which I may have, or which may accrue to me on account of my participation or the participation of my child or children in the above program. I further agree to indemnify and hold harmless and defend the Lombard Park District, the Lombard Junior Women’s Club and their officers or agents, servants, employees, volunteers, and medical staff from any and all claims resulting from injuries, damages or losses sustained by me or by my child or children, and arising out of, connected with, or in any way associated with the activities on the TLC Camp, Inc. program.

I understand that every precaution is taken to protect the safety of each participant. I agree to emergency treatment at Good Samaritan Hospital, 3815 S. Highland Ave., Downers Grove, Illinois 630-275-5900 and the administration of medication by Lombard Park District and Lombard Junior Women’s Club agents as prescribed by a physician and or nonprescription medications as may be required to safeguard the health and well-being of the participant if it is necessary during the activity(ies). I further understand that the Lombard Park District and the Lombard Junior Women’s Club carry no accident coverage on participants and that immediate medical attention and/or hospitalization will be the sole responsibility of the individual question and/or the parent or guardian.

I understand that unless specifically stated in writing at the time of this registration, photographs of participants may be taken. I realize that our rights to privacy will be protected in all photographs and publications of the Lombard Park District and Lombard Junior Women’s Club activities. I have been made to understand that no personal information other than first name and hometown will be released and his meets my approval.

I have read and fully understand the Lombard Park District and Lombard Junior Women’s Club policies pertaining to participation in the TLC Camp, Inc. program that the above information details and waiver and release all claims.

**I fully understand that TLC Camp, Inc. hours are 9:00 am to 3:00 pm Monday through Thursday and 9:00 am to 7:00 pm Friday during the week of camp.**

Printed Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if applicant is under age 21)