

PROJECT HEAL THE CHILDREN

APPLICATION ---- PLEASE TYPE OR PRINT ALL INFORMATION

CHILD'S NAME _____
GENDER (M / F) _____ DOB _____ CURRENT SCHOOL GRADE _____
PARENT / GUARDIAN'S NAME _____
PARENT / GUARDIAN'S ADDRESS _____
TELEPHONE (day) _____ TELEPHONE (night) _____
PARENT / GUARDIAN'S E-MAIL _____

TYPE OF CAMP DESIRED (circle one): DAY CAMP OVERNIGHT CAMP SPECIAL NEEDS CAMP
LOCATION DESIRED (circle all acceptable states): CT MA ME NH NJ NY PA VT OTHER: _____
HOW MANY WEEKS WOULD YOU LIKE YOUR CHILD TO ATTEND CAMP: 1 2 3 4 5 6 7 8
WHEN DO YOU WANT YOUR CHILD TO ATTEND CAMP (circle one): JULY AUGUST EITHER BOTH

LIST YOUR CHILD'S INTERESTS _____
DESCRIBE YOUR CHILD'S PREVIOUS CAMP EXPERIENCE _____
LIST YOUR CHILD'S SPECIAL NEEDS (e.g. health, dietary, medication) _____
INDICATE IF YOU ARE INTERESTED IN A RELIGIOUSLY- AFFILIATED CAMP. SPECIFY. _____

ON A SCALE OF 1 – 5, INDICATE YOUR CHILD'S LEVEL OF INTEREST IN EACH OF THESE ACTIVITIES (5 = very interested):
ARTS & CRAFTS _____ PERFORMING ARTS _____ HORSEBACK RIDING _____ SPORTS _____
WATER SPORTS _____ OUTDOOR ADVENTURE _____ OTHER: _____

PLEASE INDICATE ADDITIONAL INFORMATION YOU THINK WILL BE HELPFUL IN IDENTIFYING THE RIGHT CAMP FOR YOUR CHILD (indicate the names of three camps you are interested in): _____

IN ORDER TO PROCESS THIS APPLICATION, COPIES OF THE DECEASED PARENT'S DEATH CERTIFICATE AND THE CHILD'S BIRTH CERTIFICATE MUST BE ATTACHED.

PARENT / GUARDIAN'S SIGNATURE

DATE

**RETURN COMPLETED APPLICATION, WITH ATTACHMENTS, TO:
PROJECT HEAL THE CHILDREN
AMERICAN CAMPING ASSOCIATION – NY SECTION
1375 BROADWAY, 4TH FLOOR
NEW YORK, NY 10018**

OR FAX TO 212-391-5207