



**2010**  
**-- APPLICATION --**  
**RIVERLEA, LLC DBA**  
**CAMP RIVERLEA**

Please return to Camp Riverlea  
 c/o Joseph L. Harris  
 145 Hidden Falls Lane • Atlanta, GA 30328  
**For Boys and Girls 5-12**  
*A Camp Tradition for Durham Area Children*



	Amt.	Date Rcd.	Recpt. Sent	Sess's
Registr.				
Sess. 1				
Sess. 2				
Sess. 3				

For Office Use Only

We desire to apply for the admission of our  son;  daughter;  ward. E-mail \_\_\_\_\_ Fax# \_\_\_\_\_

Full name of child \_\_\_\_\_

Name by which child is called \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Name of School \_\_\_\_\_

School Address \_\_\_\_\_

Name of Principal \_\_\_\_\_

School Grade (that will be completed Spring 2010) \_\_\_\_\_ Camper's Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's Business \_\_\_\_\_ Phone \_\_\_\_\_ Mother's Business \_\_\_\_\_ Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred to camp by: \_\_\_\_\_

The director of the Camp assumes that she can discuss the camper with the camper's physician, teacher, or any knowledgeable person when necessary.

**DATES AND TUITION**

(Please check session for which camper is enrolling.)

- FIRST SESSION      JUNE 14 - JULY 2      (3 WEEKS)      \$890.00**
- SECOND SESSION      JULY 5 - JULY 16      (2 WEEKS)      \$595.00**
- THIRD SESSION      JULY 19 - AUGUST 6      (3 WEEKS)      \$890.00**

PARENT WILL PLEASE GIVE THE FOLLOWING INFORMATION

Frank, full answers will be of service in our helping your child.

- Names of Brothers \_\_\_\_\_ Ages \_\_\_\_\_ Names of Sisters \_\_\_\_\_ Ages \_\_\_\_\_
- Has the child ever been to camp before? \_\_\_\_\_  
If so, where? \_\_\_\_\_
- Is there any other information about your child which would add to our understanding and helping him/her? \_\_\_\_\_
- Is there any particular field or area in which you want the camp to especially help your child? \_\_\_\_\_
- Names and addresses of other children you think might be interested in Riverlea \_\_\_\_\_

**TERMS**

PLEASE READ CAREFULLY SO THAT THERE WILL BE NO MISUNDERSTANDING BETWEEN THE PARENTS AND THE CAMP.  
 HEALTH FORM will be sent to all applicants, to be returned at least two weeks before session begins.  
 LUNCH - Campers bring a bag lunch. Camp will furnish beverage.  
 REGISTRATION FEE - A \$100 registration (nonrefundable) for each session must accompany your application and the balance is due on or before opening date, or by special arrangement with the director. Fee includes transportation unless otherwise stated.  
 I enclose \$100.00 covering registration fee (nonrefundable) for each session, which is to be subtracted from camp tuition for these sessions.

Date: \_\_\_\_\_ Signed \_\_\_\_\_  
 (Parent or Guardian)



## TRANSPORTATION 2010

Please send this information with application.

Name of Camper: \_\_\_\_\_ Session:  First  
 Second  
 Third

A bus will pick up campers at the following times and places. Please indicate where your child will be picked up by checking proper box.

### PLEASE CHECK ONE:

- Forest Hills - Near Library behind tennis courts 8:15 AM - 4:30 PM
- Duke University Parking Lot - at the end of Frank Bassett Drive which is located one block from Rt. 751 on Science Drive 8:30 AM - 4:30 PM
- On Hillandale at Scout Center, across from Leohmann's Plaza 8:40 AM - 4:15 PM
- I will supply transportation to and from camp for my child

Signed: \_\_\_\_\_ Phone: \_\_\_\_\_



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- I will supply transportation to and from camp for my child

Signed: \_\_\_\_\_ Phone: \_\_\_\_\_





**2010**  
**CAMPER / STAFF - HEALTH HISTORY**

FORM 1

Participant's Name: \_\_\_\_\_  
FIRST
MIDDLE
LAST

Immunization History: Please attach a doctor's record, have your doctor complete or give all dates (month & year) for each immunization. Immunizations marked with an asterisk (\*) must be current.

Immunization	Dose 1 Month / Year	Dose 2 Month / Year	Dose 3 Month / Year	Dose 4 Month / Year	Dose 5 Month / Year	Most Recent Dose Month / Year
Diphtheria, tetanus, pertussis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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**Medication:**  
 (Includes both prescribed medicines and over-the-counter remedies including but not limited to vitamins, natural remedies, inhalers, epi-pens and bee sting kits.)

The participant will take no medication while attending camp.  
 The participant will take the following medication at home or at camp while attending camp.

**PLEASE COMPLETE BELOW FOR ALL MEDICATIONS TAKEN ROUTINELY**

Med. #1 \_\_\_\_\_ Dosage: \_\_\_\_\_ Time it is given: \_\_\_\_\_  
 Date started: \_\_\_\_\_ Reason for taking: \_\_\_\_\_  
 How given: \_\_\_\_\_

Med. #2 \_\_\_\_\_ Dosage: \_\_\_\_\_ Time it is given: \_\_\_\_\_  
 Date started: \_\_\_\_\_ Reason for taking: \_\_\_\_\_  
 How given: \_\_\_\_\_

KEEP THE MEDICATION SENT TO CAMP IN THE ORIGINAL PACKAGING / BOTTLE THAT IDENTIFIES THE PRESCRIBING PHYSICIAN (IF PRESCRIPTION DRUG), THE NAME OF THE MEDICATION DOSAGE AND THE FREQUENCY OF ADMINISTRATION.

The management of some illnesses and/or injuries may call for the use of non-prescription medication. The following non-prescription medicines may be available at camp and could be used on an as-needed basis. Please cross out any that your camper should not be given.

- Calamine Lotion
- Acetaminophen (Tylenol)
- Ibuprofen (Advil Motrin)

**2010  
CAMP RIVERLEA - CAMPER / STAFF HEALTH HISTORY**

**FORM 1**

Participant's Name: \_\_\_\_\_  
FIRST
MIDDLE
LAST

**General Health Questions (Check No or Yes by each item & record applicable date)**

**Has / Does the participant:**

	DATE:	NO	YES		DATE:	NO	YES		DATE:	NO	YES
Diarrhea / Constipation	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recent Injury, Illness or Infectious Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, BorC	_____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Ear Infections	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or Recurring Illness / Condition	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect / Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recent or Serious Injuries	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	_____	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or Seizures	_____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy or Fainting	_____	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Wheezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever been treated for ADD / ADHD / Learning Disabilities	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	_____	<input type="checkbox"/>	<input type="checkbox"/>
If female, had period & had problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever been in hospital	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seen a professional to address mental / emotional health concerns.	_____	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever treated for emotional or behavior difficulties or an eating disorder.	_____	<input type="checkbox"/>	<input type="checkbox"/>				
Had a significant life event that effects participants life.	_____	<input type="checkbox"/>	<input type="checkbox"/>								

Explain "YES" answers below:

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Any Past Medical Treatment not noted above  NO  YES (Describe):

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Dentist / Orthodontist: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are there any current physical, mental or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp or any other information we should know about the participant's health not mentioned on FORM 1 that could prevent their full participation in the camp programs and activities:  YES  NO.  
 Please describe YES answers below:

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