DREAM CAMPER Registration Form
This form MUST be completed in its entirety

Camper Name:_____ **DOB:** ___/___/___ **Age:** _____ **Male / Female**

Address: _____ **City:** _____ **Zip:** _____

Contact Person/Parent/Guardian during camp: _____

Cell Phone Number: _____ **Alternative Phone Number:** _____

Who Referred You To Dream Camp ? _____

Agency they represent (if applicable): _____

Please sign if you give permission for camper to be photographed / video recorded:

_____ _____

Signature of Parent/Guardian/Referral Source **Date**

Transportation Needed ? ____ YES ____ NO

Please Circle Camp Choice / Pick-Up Location:

Camp 1: June 13-16, 2025
Pick-Up Location select one Or ____ no transportation needed
__Colby ___ Garden City ___Dodge City ___Larned ___Great Bend ___Russell ___ Hays

Camp 2: June 17-20, 2025
Pick-Up Location select one Or ____ no transportation needed
___Wichita ___ Hutchinson ___Newton ___McPherson ___ Salina ___Russell ___Hays

Camp 3: June 23-26, 2025
Pick-Up Location select one Or ____ no transportation needed
__Colby ___ Garden City ___Dodge City ___Larned ___Great Bend ___Russell ___ Hays

Camp 4: June 27-30, 2025
Pick-Up Location select one Or ____ no transportation needed
___Wichita ___ Hutchinson ___Newton ___McPherson ___ Salina ___Russell ___Hays

DREAM Camper Health/Medication Form

Parent/Guardian – please fill this form out completely. Signature at the bottom of this form verifies agreeing to submit this medical release and consent from by electronic means. By signing/typing name were indicated - this medical release and consent form, I understand that this verification has the same legal effect and can be utilized in the same way as a written signature.

Camper Name: _____

TO BETTER SERVE THE NEEDS OF YOUR CHILD, PLEASE ANSWER ALL QUESTIONS

Is tetanus immunization current ? ___ No ___Yes ___Does not apply

Allergies to any medication? ___ No ___ Yes **Please List:** _____

Asthma ? ___ No ___ Yes **Medication:** _____

History of convulsions/seizures ____ No ___Yes **Please explain:** _____

Frequent ear infections ___ No ___ Yes

Mental Health Issues / Diagnosis ___ No ___ Yes **Please list diagnosis:** _____

Any special classes in school ___ No ___Yes **Please explain:** _____

History of bed wetting / urgency to go to the bathroom, etc. ___ No ___Yes

Any additional information that we need to know? _____

Please list any limitations or activity restrictions while at camp: _____

(NOTE: If nothing is noted, your child will be allowed to participate in all camp activities.)

Medication Permission Form

If camper has a medical KanCare card, please send a copy of the child's car with this form. PLEASE READ AND SIGN ONE OF THE FOLLOWING: We have a small supply of over-the-counter medications such as children's Tylenol, children's allergy medication, throat lozenges, children's cough syrup, anti-bacterial ointment, etc....In the event that your child needs and has requested this type of medications, do you grant permission for the staff of Dream, Inc. to supply over-the-counter, age-specific medication?

_____ **YES, my child may take over-the-counter medication with camp staff supervision.**

_____ **NO my child may NOT take any over-the-counter medication.**

For children bringing medication to camp: The medication must be in it's original container with the child's name and directions on the amount/frequency to administer medication.

_____ **I grant permission for my child to be administered their prescribed medication as prescribed.**

_____ _____

Signature of Parent/Guardian **Date**