

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 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

Is Transportation Needed?

YES

NO

PLEASE CIRCLE CAMP CHOICE/PICK-UP LOCATION:

Camp 1: June 12-15, 2026

Pick-Up Location Select One _____ or _____ No transportation needed
____ Colby ____ Garden City ____ Dodge City ____ Larned ____ Great Bend ____ Russell ____ Hays

Camp 2: June 16-19, 2026

Pick-Up Location Select One _____ or _____ No transportation needed
____ Colby ____ Garden City ____ Dodge City ____ Larned ____ Great Bend ____ 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 form by electronic means. By signing/typing name where 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 List: _____

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 the camper has a medical KanCare card, please send a copy of the child's card 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 medication, 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 the 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/Referral Source

Date