CAMP-ABILITY

This program introduces individuals to the summer camp experience! Campers gain independence, relate to others and engage in activities that bring a sense of achievement. Camp Ability will be full of engaging camp activities including boating, swimming, sports, arts and crafts, and teambuilding.

**Price:** FREE!
**Ages:** 5 +
**Day:** Saturdays
**Date:** July 7th – August 18th
**Time:** 9a – 12p
**Location:** Camp Clark
200 Hedges Pond Rd

**Camp-Ability also:**
- Strives to unlock limitations and empowers participants of all abilities to achieve a healthy, happy lifestyle
- Provides opportunities to build on social skills and cognitive learning
- Offers sensory stimulation while keeping participants engaged in the activity for extended periods of time

CAMP ABILITY CONTACT
Catherine Colantuone – Camp Director
ccolantuone@oldcolonyymca.org or 508 888 2290 x204
CAMP ABILITY REGISTRATION FORM

Participant First Name: ___________________________ Male □ Female □

Participant Last Name: __________________________ Date of Birth: __________________________

Parent/Guardian 1 Name: __________________________ Parent/Guardian 2 Name: __________________________

Address: ____________________________________________________________________________________

Preferred Daytime Phone (1): __________________________ Preferred Daytime Phone (2): __________________________

Preferred Email Address: __________________________________________________________________________

EMERGENCY OR NON-EMERGENCY AUTHORIZED PERSON (LOCAL) WHO CAN PICK UP PARTICIPANT

Contact Person 1: __________________________ Phone: __________________ Relationship: ____________

Family Physician (to be contacted): __________________________ Phone: __________________

Do you have medical insurance? ____ Carrier: __________________________

Policy/Group #: ______________________________________________________________________________

ALLERGIES

None Known □ Please list all known allergies below:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

Please explain reaction and treatment for the above allergies:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

If medication will be provided, please fill out the Authorization to Administer Medication

CHILD HAS A HISTORY OF

Asthma □ Epilepsy □ Diabetes □ Autism □ Hyperactivity/Behavioral Issues □

Frequent Headaches □ Hearing Issue □

Other: ____________________________________________________________________________________

___________________________________________________________________________________________

Please comment on indicated history: ______________________________________________________________________________

___________________________________________________________________________________________

*Please note you may be asked to meet with staff to discuss your child’s medical history

Signature of Parent/Guardian: __________________________ Date: ________________