



# Adult Special Need 2012 Application Form

*This page should be filled out by the care giver/group home/agency (residence of campers). Please fill out a camper info sheet for each applicant.*

## YOUTH FARM BIBLE CAMP

### OFFICE

Box 636  
Rosthern, SK.  
S0K 3R0

### PHONE

1-855-855-YFBC

### FAX

306-232-5167

### EMAIL

info@yfbc.ca

### WEB

[www.yfbc.ca](http://www.yfbc.ca)

Name of Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_

# of campers applying: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Place Campers' names under the preferred camp week. **If possible, mark a second choice as well.**

ASN1 - Cost \$215	ASN2 - Cost \$215	ASN3 - Cost \$215	ASN4 - Cost \$215	ASN5 - Cost \$260
June 25-29	July 2-6	July 16-20	August 6-10	August 19-24

Registration Time for all Camps: 5:00pm Pick-up Time is 1:30pm

**Remember to fill out one ASN Camper Info Sheet for each person attending camp!!**

**Please include a \$50 Deposit for each camper applying.**

*Fill out one page for each camper attending!*

Former Camper

New Camper

Name of Camper \_\_\_\_\_

Birth Date (day/month/year) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Hospitalization # \_\_\_\_\_ Province \_\_\_\_\_

### Medical/Physical Conditions

*Please give as much detail as possible, this information is given to their Camp Counselor!*

Does the applicant have Diabetes, Epilepsy, Special Diets, Hepatitis, Allergies, Asthma and/or any other condition.  Yes  No

### **IMPORTANT!**

If yes, please fully describe the specific medical condition. If more space is required, use additional paper clearly labeled with applicant's name.

Does the applicant have any physical disabilities?  Yes  No If Yes, Please Describe:

Does the applicant have problems communicating clearly?  Yes  No If Yes, Please Describe:

Are there any additional care needs for the applicant?  Yes  No If Yes, Please Describe:

Does Applicant take Medications?  Yes  No

**Please attach a copy of medications applicant is currently taking!**

### Check List

- Wears Eye Glasses
- Uses Hearing Aid
- Has Dentures
- Smoker
- Uses Cane/Walker