CAMP THRIVE LAS VEGAS - CAMPER APPLICATION (2025)

APPLICATION DEADLINE: April 7, 2025
Applications accepted thru April 7th or until such time that ALL spots have been filled.

CAMP LOCATION:
Alamo 4-H Camp and Learning Center,
1536 Alamo West Road, Alamo, Nevada, 89001.

CAMP DATES: Friday, June 6, 2025 – Sunday, June 8, 2025 (overnight camp)

YOUTH AGE GROUP: Girls (10YO - 14YO)

APPLICATION INSTRUCTIONS: Please ensure that each section is written legibly and that the application is filled out in its entirety. **Incomplete applications will not be processed.** **If the applicant is selected, both the camper and a parent/legal guardian must attend a mandatory camp meeting to be held on May 28, 2025, at 5:30 pm at the Children's Advocacy Center, 701 N. Pecos Road, Bldg. K-1, Las Vegas, NV 89101.**

Completed applications must be emailed to: campthrivelv@cac-foundation.org

CAMPER INFORMATION

Camper Full Name:	DOB:	Age:
Address:	Phone:	
Gender:	Race/Ethnicity:	
Name of Camper's School:	Camper's Grade Level:	
Is Camper in Special Education Classes? Yes | No	Shirt Size (Circle One): **SM, MED, LG, XL, XXL, XXXL** Youth or Adult Size (Circle One): **YOUTH ADULT**	

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:	Relationship to Camper:
Address:	Email:
Cell Phone:	Work Phone:
Emergency Contact Name:	Relationship to Camper:
Emergency Contact Phone:	Emergency Contact Email:

Camper Full Name: _____

CAMPER'S MEDICAL HISTORY

Does the camper have any Dietary Restrictions? Yes | No

If Yes, please specify: _____

_____

Does the camper have any food, medication, or other types of allergies? Yes | No

If Yes, please specify: _____

_____

Does the camper have any restrictions on physical activity? Yes | No

If Yes, please specify: _____

_____

Does the camper require any special accommodations? Yes | No

If Yes, please specify: _____

_____

Has the camper been hospitalized in the last five years? Yes | No

If Yes, please specify: _____

_____

_____

Does the camper carry an epi-pen? Yes | No

Date of Last Tetanus shot? _____

MEDICAL INSURANCE INFORMATION:

Insurance Provider:	Policy/Group#:
Insured's Name:	Relationship to Insured:

PRIMARY PHYSICIAN INFORMATION:

Physician's Name:	Physician's Phone:
Physician's Address:	Physician's Email:

CHILDREN'S ADVOCACY CENTER FOUNDATION

Camper Full Name: _____

Please indicate if the camper has had or has any of the following **(Check all those that apply)**:							
	ADHD		Arthritis		Asthma		Bedwetting
	Birth Defects		Bleeding/Clotting Disorders		Blood Pressure Disorders		Cancer
	Chronic Pain/Illness		Chicken Pox		Developmental/ Learning Delays		Diabetes
	Difficulty Sleeping/ Sleepwalking		Disease of Ears/ Frequent Ear Infections		Dizziness/Excessive Pain After Exercise		Easily Scared
	Fainting Spells		Frequent Diarrhea/ Constipation		Frequent Headaches		Frequent Nausea/Vomiting
	Fear of Animals		Fear of the Dark		Fear of Insects		Hay Fever
	Hearing Impairment		Heart Disease		Hernia		Intestinal Disorders
	Kidney/Bladder Disease		Lice, Scabies, or Bed Bugs in the past 12 mo.		Lung Disease		Measles
	Mental/Emotional Disorders		Mumps		Nervous System Disorders		Seizures/Epileptic Episodes
	Severe Menstrual Pain		Sinusitis		Skin Disorders/Disease		Speech Impairment
	Tuberculosis		Venereal Disease		Vision Impairment		Other _____

Does the camper take any medications? Yes | No

If Yes, please list on the next page **ALL** medications that the camper will be taking at camp, including any and all prescription or non-prescription/over-the-counter drugs. The camper will need to bring enough medication to last the entire time at camp.

Please keep **ALL** medications in their original packaging that identifies the prescribing physician, the name and dosage of the medication, and the frequency of administration. Place all medications with the camper's photo and name in a plastic zip-lock bag and write the camper's name on the outside. ALL medications must be given directly to camp personnel upon arrival to camp. Medications will be administered ONLY by the camp nurse.

CHILDREN'S ADVOCACY CENTER FOUNDATION

Camper Full Name: _____

CAMPER'S MEDICATION INFORMATION

Med #1: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #2: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #3: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #4: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #5: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #6: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #7: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Med #8: _____ Dosage: _____ Frequency: _____

Reason for taking: _____

Attach additional pages for more medications if needed.

CHILDREN'S ADVOCACY CENTER FOUNDATION

Camper Full Name: _____

PARENT/GUARDIAN ACKNOWLEDGEMENT AND AUTHORIZATION

As the Parent or Legal Guardian, I hereby acknowledge that the health history given above is, to the best of my knowledge, complete and correct in regard to the camper named below. I further acknowledge that the camper described in this packet has permission to engage in all camp activities, except as noted.

EMERGENCY AUTHORIZATION: I hereby give permission to the Children's Advocacy Center Foundation, Camp Thrive Las Vegas, and the medical personnel selected, permission to administer prescribed medications, as listed on the Camper's Medication Information sheet, including but not limited to the administration of non-prescription/over-the-counter drugs, and seek emergency medical treatment, including ordering x-rays, or other routine tests/examinations. I agree to the release of any necessary records for insurance purposes. I further give my permission to arrange any necessary emergency medical transportation as needed.

In the event I am unable to be reached in an emergency, I hereby give permission to the medical provider/physician selected by the Children's Advocacy Center Foundation and Camp Thrive Las Vegas personnel to secure and administer treatment, including hospitalization, to order injections, anesthesia and/or surgery for the camper named below. The Children's Advocacy Center Foundation retains the right to contact the child's primary physician if deemed necessary.

This form may be photocopied for use outside of camp.

Name of Camper: _____

Parent/Guardian Signature: _____

Parent/Guardian Name (Printed):_____

Date: _____

CHILDREN'S ADVOCACY CENTER FOUNDATION

Camper Full Name: _____

CONSENT FOR THERAPY

As the Parent or Legal Guardian, I hereby give permission to the Children's Advocacy Center Foundation and Camp Thrive Las Vegas to provide therapeutic treatment to:

Name of Camper: _____

I understand that the care the camper will receive will discuss topics related to past traumatic experiences and may be triggering to them. There will also be healing-focused care involved following these discussions. This care may be given during the duration of the camp for the benefit of the camper's mental and emotional well-being.

Parent/Guardian Signature: _____

Date: _____

TRANSPORTATION CONSENT

As the Parent or Legal Guardian, I hereby give permission to the Children's Advocacy Center Foundation and Camp Thrive Las Vegas to transport my child to and from Camp Thrive Las Vegas, to be held at the 4-H Camp & Learning Center located in Alamo, NV, by way of a third-party contractor, who has been contracted to provide transportation services to and from camp.

Name of Camper: _____

Parent/Guardian Signature: _____

Date: _____

BAG CHECK CONSENT

As the Parent or Legal Guardian, I hereby give permission to the Children's Advocacy Center Foundation and Camp Thrive Las Vegas to have my camper's belongings checked for any unauthorized weapons, alcohol, or drugs.

Name of Camper: _____

Parent/Guardian Signature: _____

Date: _____

CHILDREN'S ADVOCACY CENTER FOUNDATION