



2010

APPLICATION

CATALINA ISLAND SEA ADVENTURE CAMP

PLEASE COMPLETE ALL INFORMATION AND RETURN WITH PAYMENT

| | |
|--|----------|
| Office Use Only | |
| <input type="checkbox"/> Deposit Paid | \$ _____ |
| <input type="checkbox"/> Souvenir Amt. | \$ _____ |
| <input type="checkbox"/> Amount Due | \$ _____ |

PRICE \$455 PER CAMPER

CAMP DATE REQUESTED:

July 12-16 July 19-23 July 26-30 August 2-6

ALTERNATE CAMP DATE: (If first choice is filled you will be notified)

July 12-16 July 19-23 July 26-30 August 2-6

CAMPER INFORMATION:

Campers Name: _____ Nickname: _____ None

Camper: Male Female Age: _____ Birthday: _____

Parents Name: _____ Email: _____

Telephone: Home () _____ Work/Cell () _____

Address: _____

Will airport pick-up and/or drop-off be needed (fee will depend which airport)? Yes No Undecided

SOUVENIRS: Please fill out order form and submit with application.

MEDICAL FORM: Please submit medical form with application. If any changes to form prior to camp date please submit updates.

METHOD OF PAYMENT: Check: # _____ VISA MasterCard
Credit Card #: _____ - _____ - _____ - _____ Expiration Date (m/yr): ____/____
Name on Card: _____

A **deposit** of at least 50% **MUST** accompany each application with the balance due 14 days prior to camp.
A \$3.00 service charge will be added to all credit cards.
May be Tax Deductible. Check with your tax professional.

Please put Balance Due on above Credit Card 14 days prior to camp.

CANCELLATION POLICY:

- 45 days prior Full Refund less \$25 Administration fee
- 44-14 days prior 50% Refund less \$50.00 Administration fee
- Less than 2 weeks prior to Camp Date no refund

Cancellations for medical reasons require a letter from a licensed physician in order to receive a refund of tuition. If Children's Maritime Foundation cancels a camp for any reason the whole amount will be refunded or will be applied to another date of the campers choice.

I grant my permission for the above named child to attend the Children's Maritime Foundation's CATALINA ISLAND SEA ADVENTURE CAMP, session as listed above, and have provided true and accurate information about this child.

PARENT SIGNATURE: _____ DATE: _____

Mailto:
CHILDREN'S MARITIME FOUNDATION
4676 Lakeview Ave. #109-E Yorba Linda, CA 92886-9933
(714) 970-8800 office • (714) 970-8474 fax
theamericanpride@aol.com

CHILDREN'S MARITIME FOUNDATION

MEDICAL, HEALTH, AND PHOTO REGISTRATION FORM

Name (last, first): _____ School/Organization _____ Date: _____

| | | | |
|---------------------------------------|------------------------|------------------|--|
| PARTICIPANT'S NAME (Please print) | AGE | BIRTHDATE / / | SEX <input type="checkbox"/> Male <input type="checkbox"/> Female |
| ADDRESS (include city and zip) | DAY PHONE () - | | |
| | EVENING PHONE () - | | |
| NAMES OF CUSTODIAL PARENT/GUARDIAN(S) | | | E-MAIL |

| | | | |
|----------------------------|--------------------|------------------------|---------------------|
| EMERGENCY CONTACT NAME (1) | DAY PHONE () - | EVENING PHONE () - | CELL PHONE () - |
| EMERGENCY CONTACT NAME (2) | DAY PHONE () - | EVENING PHONE () - | CELL PHONE () - |

HEALTH HISTORY: The following information must be filled in by the parent/guardian. Please complete the form in detail so that we can be aware of your child's needs.

PLEASE NOTE ANY HEALTH PROBLEMS YOUR CHILD MAY HAVE EXPERIENCED IN THE MONTH PRIOR TO ATTENDING:

| Has/does the participant: | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Ever have bleeding / clotting disorders? | <input type="checkbox"/> | <input type="checkbox"/> | Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have convulsions? | <input type="checkbox"/> | <input type="checkbox"/> | Have hay fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had poison oak? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever have chronic ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been allergic to penicillin? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have heart defects / hypertension? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been allergic to iodine? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had psychiatric treatment? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been allergic to latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been allergic to bee stings? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had seasickness? | <input type="checkbox"/> | <input type="checkbox"/> | Any physical impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses or glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had joint problems? | <input type="checkbox"/> | <input type="checkbox"/> | Other (Please list) | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE EXPLAIN ANY "YES" ITEMS CHECKED:

EXPLAIN ANY ACTIVITY RESTRICTIONS:

ANY SPECIAL NEEDS YOU WOULD LIKE YOUR CHILD'S COUNSELOR TO KNOW ABOUT:

MEDICATION Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescriptio drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage: _____ Specific time taken each day: _____

Med #2 _____ Dosage: _____ Specific time taken each day: _____

Med #3 _____ Dosage: _____ Specific time taken each day: _____

Does the participant carry: An Inhaler? Yes No An Epi-pen? Yes No

Non- Prescription Medications: I authorize the following medications to be administered as needed:

| | | | |
|---|--|--|--|
| Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No | Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No | Tums <input type="checkbox"/> Yes <input type="checkbox"/> No | Sudafed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chloraseptic <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough Drops <input type="checkbox"/> Yes <input type="checkbox"/> No | Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No | Calamine Lotion <input type="checkbox"/> Yes <input type="checkbox"/> No |

Over, please

SOUVENIR ORDER FORM

TALLSHIP AMERICAN PRIDE CHILDREN'S MARITIME FOUNDATION

● **T-SHIRTS**- High quality Hanes Beefy-T's Sizes- Small, Medium, Large, X-Large, XX-Large

BURGUNDY (With White Logo/ PRE-SHRUNK ADULT SIZES ONLY)

Small Medium Large X-Large XX-Large

WHITE (With Burgundy Logo / PRE-SHRUNK ADULT SIZES ONLY)

Small Medium Large X-Large XX-Large

NAVY (With White Logo / PRE-SHRUNK ADULT SIZES ONLY)

Small Medium Large X-Large XX-Large

NATURAL (With Burgundy Logo / PRE-SHRUNK ADULT SIZES ONLY)

Small Medium Large X-Large XX-Large

** Please enter the number of shirts in the Boxes**

TOTAL NUMBER OF SHIRTS _____ @ \$12.00 each = _____

FRONT



BACK



● **LONGSLEEVE SHIRTS**- NAVY ONLY (With White Logo / PRE-SHRUNK ADULT SIZES ONLY)

Small Medium Large X-Large XX-Large

** Please enter the number of shirts in the Boxes**

TOTAL NUMBER OF SHIRTS _____ @ \$16.00 each = _____

● **HATS** (Beige with Burgundy Embroidered Logo) One Size Fits All

TOTAL NUMBER OF HATS _____ @ \$15.00 each = _____



● **COLOR POSTCARDS** (A 5½" x 7" picture of the American Pride)

TOTAL NUMBER OF POSTCARDS _____ @ \$0.75 each = _____



● **PATCHES** (Embroidered Logo 3.5" iron on)

TOTAL NUMBER OF PATCHES _____ @ \$2.00 each = _____

● **SWEATSHIRTS** (Hooded ZIP-UP Navy Blue only with Logo on Front & Back)

Adult Sizes Only

Small Medium Large X-Large XX-Large

Please enter the number of sweatshirts in the Boxes

TOTAL NUMBER OF SWEATSHIRTS _____ @ \$25.00 each = _____



TOTAL AMOUNT OF YOUR ORDER \$ _____

You **MUST** Fax or mail your "GROUP" order 5 days **before** your arrival to the ship!

Your group order will be waiting for you at the American Pride.

If you have any questions, please call the:

Children's Maritime Foundation
Office (714) 970-8801/ FAX (714) 970-8474
4676 Lakeview Ave. #109-E • Yorba Linda, CA 92886