



Foundation Running Camps

19 Oxford Place
 Rockville Centre, NY 11570
 516-376-0286
www.FoundationXCCamp.com

2010 Foundation Running Camps - Registration

Foundation Long Island

July 12 thru July 16
 Bethpage State Park
 8:00am – 12:00pm

Foundation Boston

July 19 thru July 23
 Franklin Park
 8:00am – 12:00pm

Foundation Sleepaway

August 22 thru August 27
 Camp Pontiac
 Copake, NY

Last Name _____ First _____ Date of Birth _____

Grade Entering _____ Gender _____ Home Phone _____ Email _____

Street Address _____ Town _____ State _____ Zip _____

Shoe Size _____ T-Shirt Size _____ High School/Middle School _____ Coach _____

Best 5k time _____ Best 1600m or 1500m time (circle one) _____

Mom _____ Phone # _____ Email _____

Dad _____ Phone # _____ Email _____

<p>Please check one option:</p> <p>_____ Bethpage, NY Day Camp ONLY (July 12 thru July 16)</p> <p>_____ Boston, MA Day Camp ONLY (July 19 thru July 23)</p> <p>_____ Sleepaway Camp ONLY (August 22 – August 27)</p> <p>_____ Bethpage Day Camp AND Sleepaway Camp Combo</p> <p>_____ Boston Day Camp AND Sleepaway Camp Combo</p> <p>Please check those that apply (for Sleepaway ONLY):</p> <p>_____ Cross Country Program</p> <p>_____ Middle School Program</p> <p>_____ Race-Walking Program</p> <p>_____ Speed & Fitness Camp</p> <p>_____ Leadership Academy (\$25 materials fee)</p> <p>_____ Sports Medicine Internship (\$25 materials fee)</p> <p>Please check Bus options (for Sleepaway ONLY):</p> <p>_____ Bus TO Camp Pontiac (August 22 ONLY)</p> <p>_____ Bus FROM Camp Pontiac (August 27 ONLY)</p> <p>_____ Round-trip (To AND From Camp Pontiac)</p> <p>_____ Own Transportation</p>	<p>Tuition:</p> <p>Take advantage of Early Bird Rates! (before April 1st)</p> <p>Day Camp ONLY (Bethpage OR Boston) = \$250.00 (\$225.00 Early Bird)</p> <p>Sleepaway Camp ONLY = \$495.00 (\$450.00 Early Bird)</p> <p>Combo of Any Day Camp and the Sleepaway Camp = \$595.00 (\$550.00 Early Bird)</p> <p><i>Additional Programs at Foundation Sleepaway</i></p> <p>Leadership Academy = Add \$25.00</p> <p>Sports Medicine Internship = Add \$25.00</p> <p>Coach Bus To and/or From Camp = Any One Way Trip, Add \$40.00 Round Trip, Add \$75.00</p> <p>Camp Fee = \$ _____</p> <p>Additional Program Fees = \$ + _____</p> <p>Bus Fee = \$ + _____</p> <p>Minus coupons or other discounts = \$ - _____ (please list here) _____</p> <p>Total Enclosed = \$ _____</p>
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Make check payable to:
Foundation Cross Country
 and mail with Registration to:
19 Oxford Place
Rockville Centre, NY 11570

Camp information, physical forms, bus information and directions to camp will be mailed to you when we receive your registration.

Follow us on Facebook!  FoundationXCCamp

Foundation Running Camps – Camper Health Form

(To be filled out by a parent. Please return with Registration Form)

Camper Information

Last _____ First _____ Date of Birth _____ Age at Camp _____

Street Address _____ Town _____ State _____ Zip _____

Mother's Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ email Address _____

Father's Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ email Address _____

Emergency Notification

Name _____ Relationship to Camper _____ Phone _____

Name _____ Relationship to Camper _____ Phone _____

Physician/Pediatrician _____ Phone _____

Dentist/Orthodontist _____ Phone _____

Insurance Information

Is the camper covered by family medical insurance? Yes _____ No _____

If yes, please indicate the carrier or plan name. _____

Policy Holder's Name _____ Group Number _____

Please attach a copy of the Health Insurance Card to be used in the rare event that medical treatment is necessary.

Medical Permission Statement

I hereby give Foundation Running Camps permission to provide routine health care, administer prescribed medications and/or take my child to any hospital facility or outside doctor when deemed necessary. Furthermore, I hereby give permission to such hospital or outside doctor to authorize x-rays and emergency treatment if deemed necessary. I understand that all medical bills for services rendered by anyone other than camp's medical staff are my responsibility. I authorize the release of any medical information or records related to treatment, referral, billing or insurance purposes related to my child. This form may be photocopied for trips out of camp.

Signature _____ Date _____

Printed Name _____

Camper's Medical Background

<p>Health History (check those that currently apply)</p> <p><input type="checkbox"/> Headaches/Migraines</p> <p><input type="checkbox"/> Head injury/Loss of consciousness</p> <p><input type="checkbox"/> Seizure disorder/ Date of last seizure _____</p> <p><input type="checkbox"/> Glasses/Contact lenses</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Ear infections</p> <p><input type="checkbox"/> Hearing impaired</p> <p><input type="checkbox"/> Heart disease/Defect/Murmur</p> <p><input type="checkbox"/> High/Low blood pressure</p> <p><input type="checkbox"/> Fainting/Dizziness</p> <p><input type="checkbox"/> Strep infections</p> <p><input type="checkbox"/> Mono</p> <p><input type="checkbox"/> Asthma/Exercise induced asthma</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Chest pain, especially with exercise</p> <p><input type="checkbox"/> History of poison ivy</p> <p><input type="checkbox"/> Skin problems/Eczema/Impetigo</p> <p><input type="checkbox"/> Sun sensitivity</p> <p><input type="checkbox"/> Lice in the past year</p> <p><input type="checkbox"/> Chicken Pox/Date _____</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Special dietary regimen</p> <p><input type="checkbox"/> Upset stomach/Diarrhea/Constipation</p> <p><input type="checkbox"/> Dehydration</p> <p><input type="checkbox"/> Motion sickness</p> <p><input type="checkbox"/> Back/Neck problems</p> <p><input type="checkbox"/> Knee/Joint pain or swelling</p> <p><input type="checkbox"/> Lyme disease</p> <p><input type="checkbox"/> Bed wetting</p> <p><input type="checkbox"/> Sleep disturbances/Sleepwalking</p> <p><input type="checkbox"/> Prior surgery/injury</p> <p><input type="checkbox"/> Bleeds easily</p> <p><input type="checkbox"/> Emotional difficulty</p> <p><input type="checkbox"/> If female, abnormal menstrual cycle</p> <p><input type="checkbox"/> Other _____</p>	<p>Allergies</p> <p><input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> Sulfa</p> <p><input type="checkbox"/> Cephalosporin</p> <p><input type="checkbox"/> Erythromycin</p> <p><input type="checkbox"/> Fluoroquinolones</p> <p><input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> Peanuts/Nuts</p> <p><input type="checkbox"/> Insect stings</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Animal dander</p> <p><input type="checkbox"/> Other drugs _____</p> <p><input type="checkbox"/> Other Food Allergies _____</p> <p>Does your child have an EPI-PEN? Yes _____ No _____</p> <p>Please provide any additional information regarding allergies here:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Please explain any checked answers:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Is your child currently receiving any form of medical treatment or taking any medication? Yes _____ No _____

If yes, please explain (please include medication, dose and purpose): _____

Name of physician treating for above condition: _____ Phone _____