



Allandelle

girl ♥ camp 2010

GIRL CAMPER INFORMATION

Girl's last name:		First:	Middle:	Family status (check all that apply) Dad <input type="checkbox"/> Mom <input type="checkbox"/> Brothers <input type="checkbox"/> Sisters <input type="checkbox"/>		
Is this your preferred name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your preferred name?		T-Shirt Size? <input type="checkbox"/> Ad-XS <input type="checkbox"/> Ad-S <input type="checkbox"/> Ad-M <input type="checkbox"/> <input type="checkbox"/> Ad-L <input type="checkbox"/> Ad-XL		Birth Date: / /	Age:
Street address:			Social Security # - -		Home phone # ()	
P.O. Box:	City:		State:	ZIP Code: ---	REGISTRATION DEADLINE APRIL 30, 2010	
Grade entering	Preferred Session: June 6-11 (5-6 grade) _____ June 20-25 (5-6 grade) _____ July 11-16 (7-9 grade) _____ July 25-30 (TBA) _____ Aug. 1-6 (7-9 grade) _____			Registration Fee: \$575 ck# _____ Minimum Deposit: \$150 ck# _____		
You chose Allandelle Girl Camp because? (please check one box): <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Parent's request <input type="checkbox"/> Invitation <input type="checkbox"/> Other				Returning camper? Yes No		
Have other family members attended Allandelle Girl Camp? _____ Name/s _____						

INSURANCE INFORMATION

(Please include a copy of insurance card, front and back.)

Person responsible for bill:	Birth Date: / /	Address: (if different)		Home phone # ()	
Is this person at camp?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation:	Employer:	Employer address:		Employer phone # ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
<input type="checkbox"/> Welfare (Please provide coupon)			<input type="checkbox"/> Other		
Subscriber's name:	Subscriber's S.S. # - -	Birth Date: / /	Group #	Policy #	Co-payment: \$
Camper's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group #	Policy #
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to camper:	Home phone # ()	Work phone # ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize (Name of Hospital/practice) or insurance company to release any information required to process my claims.

Patient/Guardian signature _____

Date _____