

Program Registration



Participant	First Name:		Last Name:		Birthdate:	
	E-Mail:			Program Registering:		
	Hearing Loss: <input type="checkbox"/> Deaf <input type="checkbox"/> Hard-Of-Hearing <input type="checkbox"/> Hearing				Gender:	
	Language Spoken: <input type="checkbox"/> Spoken English <input type="checkbox"/> ASL <input type="checkbox"/> Other:				T-Shirt Size:	
	Address:					
	City:		State:		Zip Code:	
	Home Phone:		<input type="checkbox"/> Voice <input type="checkbox"/> VP		Mobile:	

Guardian / Emergency	For participants under 18, please share guardians. For others, please share emergency contacts.						
	Contact Name:				<input type="checkbox"/> Deaf <input type="checkbox"/> Hard-Of-Hearing <input type="checkbox"/> Hearing		Relationship:
	Full Address (if different from participant):						
	Home Phone:		<input type="checkbox"/> Voice <input type="checkbox"/> VP		Mobile:		<input type="checkbox"/> Voice <input type="checkbox"/> VP <input type="checkbox"/> SMS
	E-Mail:						
	Contact Name:				<input type="checkbox"/> Deaf <input type="checkbox"/> Hard-Of-Hearing <input type="checkbox"/> Hearing		Relationship:
	Full Address (if different from above):						
	Home Phone:		<input type="checkbox"/> Voice <input type="checkbox"/> VP		Mobile:		<input type="checkbox"/> Voice <input type="checkbox"/> VP <input type="checkbox"/> SMS
E-Mail:							

Medical	Primary Physician:		Physician Phone:	
	Insurance Carrier:		Insurance Number:	
	Do you have or had any of the following chronic illness?			
	<input type="radio"/> None <input type="radio"/> Asthma <input type="radio"/> Bleeding Disorder <input type="radio"/> Cancer <input type="radio"/> COPD <input type="radio"/> CVA / TIA <input type="radio"/> Diabetic	<input type="radio"/> Dialysis/Renal <input type="radio"/> Gastrointestinal <input type="radio"/> Headaches <input type="radio"/> Hepatitis <input type="radio"/> HIV + <input type="radio"/> Hypertension <input type="radio"/> Paralysis		<input type="radio"/> Psychological <input type="radio"/> Seizures <input type="radio"/> Substance Abuse <input type="radio"/> TB <input type="radio"/> Unknown Other _____ _____
	List any medical conditions or serious injuries that we should be aware of:			
	List any allergies that we should be aware of:			
	List any dietary limitations:			
	List all medications you will be taking during the program (attach extra paper if needed):			
	Name	Amount	Frequency	Notes
Medical Notes (attach extra sheet if needed):				

Payment	A \$50 non-refundable processing fee is required. Please enter the total cost of the program you are registering for. For installments, all fees must be paid before the program starts.	
	Total Amount Committed:	<input type="checkbox"/> I'll pay one-time in full
	<input type="checkbox"/> Money Order/Check (Payable: Aspen Camp)	<input type="checkbox"/> I'll pay in installments (credit/debit only)
	<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Please charge me for _____ (amount) every
	Number: _____ Expires: _____	<input type="checkbox"/> Week: on _____ (day)
Name on Card: _____ CVC: _____	<input type="checkbox"/> Month: on _____ (day)	
	until the invoice is paid in full.	

Arrival		Departure	
Date: _____	Time: _____	Date: _____	Time: _____
<input type="checkbox"/> At Aspen Camp <input type="checkbox"/> Pick Up At:		<input type="checkbox"/> At Aspen Camp <input type="checkbox"/> Pick Up At:	
By (details are required for quality services)		By (details are required for quality services)	
<input type="checkbox"/> Air (Airline: _____ Flight #: _____)		<input type="checkbox"/> Air (Airline: _____ Flight #: _____)	
<input type="checkbox"/> Bus/Train (Carrier: _____ Trip #: _____)		<input type="checkbox"/> Bus/Train (Carrier: _____ Trip #: _____)	
<input type="checkbox"/> Personal Car (Drop-Off By: _____)		<input type="checkbox"/> Personal Car (Pick-Up By: _____)	
Note: _____			

Personality	Please tell us more about you. This section is optional but will help improve our programs.	
	Which camp have you experienced? <input type="checkbox"/> ACDHH <input type="checkbox"/> YLC <input type="checkbox"/> CM7 <input type="checkbox"/> Lion <input type="checkbox"/> Other:	
	What do you hope to accomplish at ACDHH?	
	What are you most excited about during this program?	
	What are you most concerned about during this program?	
	What do you enjoy in general?	
	What do you not enjoy in general?	
	P-K12 Attended: _____	College Attended: _____
Number in Household: _____	Total Household Income: _____	

Release & Confirmation	Please confirm understanding of the following releases by initializing each section. (Aspen Camp of the Deaf & Hard of Hearing = ACDHH)	
	I give permission to ACDHH to administer or obtain any medical attention or treatment for illness, accident, or injury occurring or identified during my stay at ACDHH. Initial: _____ (Guardian for under 18)	
	I understand the risks involved associated with camp activities and facilities and release ACDHH and all partners from all liability arising from my participation. I am capable of engaging the activities I participate while at ACDHH. Initial: _____ (Guardian for under 18)	
	I hereby give permission to ACDHH to use any general information, my name, and media of me for any promotional purposes without notifying me. Initial: _____ (Guardian for under 18)	
	I confirm that all the information above is understandable and answered accurately to my knowledge.	
	Signature: _____	Date: _____
	Guardian Signature: _____	Date: _____
	Please e-mail or fax this registration form to Aspen Camp at info@aspencamp.org or 970-923-0643. We will confirm with you and send you additional information and forms as needed by 5 to 7 business days.	