

SSDHHC Literacy Camp Application
***** Deadline for applications: June 1, 2010 *****

**Mail to: SSDHHC Literacy in the Village Camp,
300 East Swissvale Avenue, Pittsburgh , PA. 15218.
E-mail: skitchen@wpsd.org Phone: 412-244-4269**

General Information : (Please print or type)

Camper's Name: _____ Age: _____ **D.O.B.** ___/___/___

Address: _____

City/State/Zip: _____

Telephone/VP Number: () _____

Parent/Guardian Name: _____

Daytime Telephone Number: () _____

Cell Phone / text Number () _____

Parent/Guardian E-Mail: _____

School Attended: _____

Grade as of Fall 2010: _____

EMERGENCY CONTACTS (If parents/guardian not available)

Name and Relationship:

_____ / _____

Daytime Phone /Text # () _____ () _____

Names of persons authorized to pick up camper.

Name: _____ Relationship _____

Phone/ Text:() _____

Name: _____ Relationship _____

Phone/ Text :() _____

Insurance Data: (PLEASE attach a copy of medical card.)

_____ Medical Insurance _____ Medical Assistance (ACCESS)

Insurance Company/Plan Name:

DAILY ARRIVAL & PICK-UP AT WPSD CAMPUS:

Arrival time: 9:00AM

Pick-up time: 3:00PM

Medical Consent:

A. I certify I have insurance in force to cover injuries which may occur to my child while attending the Western Pennsylvania School for the Deaf Summer Camp. WPSD will not be responsible for medical expenses as a result of illness or an accident or emergency incurred while my child is a camper .

B. I give my consent for the WPSD Summer Camp medical staff to administer my child’s prescribed medication or other over-the-counter medicines (Tylenol, cough medicine) to be administered pursuant to the printed directions on the medication label.

C. I consent to allow the Western Pennsylvania School for the Deaf to give proper medical attention to _____(Camper’s name.) Also, any hospital, offices, personnel and physician providing medical or surgical services to the above named child may rely on the consent or authorization executed by WPSD with the same force and effect as if personally executed by me at the same time that such consent or authorization is obtained. I understand that I will be notified as soon as possible should such medical attention be needed.

D. The Western Pennsylvania School for the Deaf has my permission to correspond with the family doctor of any of the clinics or schools where my child has been seen if a need is indicated.

E. I hereby release the Western Pennsylvania School for the Deaf and its administration, directors, employees, agents and subcontractors, from any and all liability for bodily injury, or cost of medical treatment therefore, or injury incurred as a result of he administration of emergency treatment.

Your signature below indicates consent for sections A, B, C, D, and E.

Signature of Parent/Legal Guardian and Date

Parental Consent Release:

I (we) hereby grant the Western Pennsylvania School for the Deaf PERMISSION to photograph or otherwise depict our child, _____ and to publish any such depiction along with his name, age and address in connection with any publicity program or professional activity. I (we) understand that any depiction, may be used in connection with newspaper articles, television, WPSD web site, radio programs, motion pictures, school publications, professional journals, and in other proper circumstances.

Signature of Parent/Legal Guardian and Date

Signature of Parent/Legal Guardian and Date

Release Information :

Name and address of newspapers most often read in your home: