



## Diocese of Wheeling-Charleston 2019 Camp Bosco Application



Camper's Name \_\_\_\_\_ Grade (*3<sup>rd</sup>-12<sup>th</sup> - at time of camp*) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender M/F Age (*at time of camp*) \_\_\_\_\_ Shirt Size \_\_\_\_\_ (shirts for sale at camp)

For 7<sup>th</sup>-9<sup>th</sup> Graders only: **(Please circle one)** Base Camp (*stay in the dorms all nights*) **OR**

Trail Camp (*1-2 night back-packing up the mountain*)

School Attending \_\_\_\_\_ Has your child received his/her First Communion? Yes \_\_\_ No \_\_\_

Crew Mate Request: \_\_\_\_\_ Parish or Church \_\_\_\_\_

**Please circle the week you wish to attend:** June 30- July 6    July 7-13    July 14-20    July 21-27

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Best phone number where parent can be reached \_\_\_\_\_

**COST: \$325**

Please make check payable to:  
DWC and mail it to the address below!!

**Insurance Information:**

I understand that all medical expenses incurred by my son/daughter are my responsibility and should be directed to the attention of my insurance carrier.

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy # \_\_\_\_\_ Name on policy \_\_\_\_\_ Employer's name \_\_\_\_\_

Should my son/daughter, \_\_\_\_\_, need the services of a doctor, I authorize the camp directors to act on my behalf.

Emergency contact & number (*required*) \_\_\_\_\_

For headaches, we stock Tylenol and Advil and for bee stings we have Benadryl. If necessary, can we administer the above medications to your child? **Yes / No**

Is there any special medical or personal information we may need to know about your child (such as allergies, prescribed medications, illnesses, family situations, physical or etc.)?  
\_\_\_\_\_  
\_\_\_\_\_

I authorize that pictures taken may be used for advertising purposes for Camp Bosco. **Yes / No**

I authorize my child to do all activities, such as: horseback riding, zip-lining, climbing tower, swimming and giant swing with well-trained supervision. **Yes / No** (If No, please list which activity: \_\_\_\_\_)

Print Parent's Name \_\_\_\_\_

Parent Signature \_\_\_\_\_

**Application and money must be returned to: Office of Youth & Young Adult Ministry, Attn: Heather Bise,  
PO Box 230, Wheeling, WV 26003**