



**Important: Registration is incomplete until all documents are received by mail**

## **COUNSELOR MAIL-IN INSTRUCTIONS**

### **Instructions:**

Email confirmation from PayPal/Gokuldham website is your receipt of payment.

Please print out the Confirmation email and attachment received after finishing Gokuldham Camp Camper Registration Part I.

Correct any errors on Part I form if needed.

Once we receive all required documents, we will notify you with your Registration.

All counselors are required to submit a statement of interest-why you would like to attend camp as counselors (minimum 200 words).

## **MAIL-IN INSTRUCTIONS**

Please mail the following EIGHT documents TOGETHER within TEN Business days of on-line registration. Please send all documents via **USPS MAIL ONLY**

1. Confirmation email received after finishing Gokuldham Camp Camper Registration Part I
2. Email confirmation for payment from Paypal/Gokuldham website (payment receipt)
3. Statement of interest - "Why you would like to attend came as counselor"
4. Signed Consent and Permission Slip (Pg. 2)
5. Proof of date of birth (Copy of Birth Certificate or a copy of Passport)
6. Health Insurance Card: Front and back copy
7. Health Information Form (Pg. 3)
8. Medical Clearance Form (pg. 4)

**Counselor will be admitted after online payment, and upon approval by the Gokuldham committee.**

**Mail all documents to:**

**Tushar Kadakia**  
1817 Magnolia Bluff Way  
Duluth, GA 30097



## Signed Consent and Permission

Completed by Parent / Guardian if under 18

|   |       |
|---|-------|
| Name of Counselor                             |       |
| Name of Parent/Legal Guardian                 |       |
| Signature by self or by Parent/Legal Guardian | Date: |
| Relation to Camper                            |       |



## **Health Information Form-Camper/Counselor**

TO BE COMPLETED BY PARENT (if under 18)

Camper/Counselor's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. If you/your child is allergic to/have any medical condition. Please check all that apply.

Drug \_\_\_ Food \_\_\_ Seasonal \_\_\_ Bee sting/insect \_\_\_ Any other \_\_\_\_\_

Please specify: \_\_\_\_\_

2. (Do you/Does your child) take any medication for this allergy/condition? (Check all that applies)

Daily \_\_\_ As needed \_\_\_ No medication is needed \_\_\_\_\_

Please list medication(s), dosage and frequency, including emergency medicine child carries:

3. Is there a need to keep medication at camp? \_\_\_\_\_ Yes \_\_\_ No

4. Are there any limitations/ restrictions of physical activities at camp due to allergies/condition?

Yes \_\_\_ No \_\_\_, Please specify if yes

5. What are the symptoms (you exhibit / your child exhibits) when having an allergic reaction/medical condition? \_\_\_\_\_

6. (Have you/has your child) ever been hospitalized, gone to the emergency room, or visited the doctor due to an allergic reaction?

Yes \_\_\_ No \_\_\_, if yes, please explain: \_\_\_\_\_

I, \_\_\_\_\_ give permission for my child to receive the

above medication as directed. (If under 18). I understand that there is no physician available at camp. (I am/my child is) trained to self-administer regular medications and emergency medications including EpiPen injection. I will send all regular and emergency medication to camp.

Printed Name of Parent/Guardian/Self Signature Date

Emergency Contact numbers: \_\_\_\_\_



## **GOKULDHAM CAMP**

### **Medical Clearance Form-Camper/Counselor**

(This form must be completed by the Child's Physician)

Camper/Counselor

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medical condition(s):

\_\_\_\_\_

Food, environmental or drug allergy:

\_\_\_\_\_

Name of medication:

\_\_\_\_\_

Length of time and frequency of

dosage: \_\_\_\_\_

Does child need to carry any emergency medicine? Yes \_\_\_\_\_ No \_\_\_\_\_

Please specify:

\_\_\_\_\_

Are there any restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes what and for how long?

Please specify:

\_\_\_\_\_

Please check one:

{ } I understand that there is no medically trained person available at Camp. My patient is trained (if he/she is prescribed) to administer all Emergency medications, including EpiPen.

{ } I certify that my patient is capable of attending camp and is free of any communicable disease.

{ } I certify that he/she is NOT capable of attending camp.

Extra

notes: \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_

Signature of

Physician \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact number: \_\_\_\_\_