Camper Application 2025

Camp Details

- Date: Monday, August 4 through Friday, August 8, 2025
- Time: 8:30 am to 12:30 pm
- Location: First Presbyterian Church of Santa Barbara – 21 E Constance Ave, Santa Barbara, CA 93105
- Open to children who will be 6 – 12 years old and entering grades 1 – 6 on September 1, 2025
- **Campers must bring their own lunch and water bottle**. A snack is provided each day.

Applications and Physician Referral are due by July 14, 2025. Applications can be submitted by:

- Email: campwheez@sansumclinic.org
- Mail: Sansum Clinic Allergy, PO BOX 1200, Santa Barbara, CA 93102-1200

Call with any questions or to confirm your application has been received: (805) 681-7635.

Camper Application 2025

PLEASE PRINT CLEARLY

Child's Name _____ Date of Birth _____

Child's Pronouns (circle one) she/her he/him they/them other_____

Grade in September _____

Address _____
street city zip code

Phone Number _____

Email _____

How did you hear about Camp Wheez? _____

Dietary Restrictions/Food Allergies _____

_____

EMERGENCY CONTACTS – Provide at least 2

1. Name _____ Relationship to Child _____

   Preferred Phone Number _____

   Alternate Phone Number _____

2. Name _____ Relationship to Child _____

   Preferred Phone Number _____

   Alternate Phone Number _____

3. Name _____ Relationship to Child _____

   Preferred Phone Number _____

   Alternate Phone Number _____

Camper Application 2025

Child Name _____ Date of Birth _____

AUTHORIZATION AND CONSENTS

Please initial after each section and sign at the bottom of the page.

PARTICIPATION AND EMERGENCY TREATMENT WAIVER **Initial here _____**

In consideration for being allowed to register and participate in Camp Wheez, sponsored by Sansum Clinic, held August 4 through August 8, 2025, as parent/guardian I release Sansum Clinic and its partner organization Sutter Health, along with their affiliates, subsidiaries, incorporators, physicians, board members, trustees, officers, directors, employees, agents, independent contractors and volunteers, from any liability for damages, injuries, or losses which may result from participation in Camp Wheez, including any necessary transportation. I have reviewed the scheduled activities, and my child has permission to engage in all such activities except as noted in writing by a physician or parent/guardian. I give permission to the camp physician to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization or other treatment is required, my child is to be referred to an appropriate physician and all care and treatment will be at my expense.

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE **Initial here _____**

I consent and authorize Camp Wheez to use and reproduce photographs or videos of my child taken while participating at Camp Wheez, and written comments made by or about my child in connection with Camp Wheez, for promotional and informational materials.

RELEASE FOR TRANSPORT HOME **Initial here _____**

At the conclusion of camp, camp staff may release my child to the individual(s) designated below. I understand that under no circumstances will my child be released to anyone not specified below.

People who are allowed to pick up my child are:

1. Parent/Guardian Name _____ Phone _____
2. Parent/Guardian Name _____ Phone _____
3. Other _____ Relationship to Child_____ Phone _____

I understand and agree to all of the above.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Name (print) Date

Camper Application 2025

PHYSICIAN REFERRAL – please print clearly

Physician Name _____

Patient Name _____ Date of Birth _____

Date Last Seen _____

Current Medications _____

_____

"Normal" Peak Flow Rate _____

Asthma is: _____ Mild Intermittent _____ Mild Persistent

_____ Moderate Persistent _____ Severe Persistent

Primary Allergies _____

Other Significant Medical Conditions _____

_____

Although Camp Wheez is medically supervised, your patient will continue to be under your direct medical care.

I would like the above-named patient to be enrolled in Camp Wheez. All breathing and exercise training is to be geared to the patient's capabilities.

_____ _____

Physician Signature Date

_____ _____

Physician Name (print) Phone

_____

Address, City, State, Zip Code

All forms are due by **July 14, 2025**. Email completed forms to campwheez@sansumclinic.org or mail to Sansum Clinic Allergy, PO BOX 1200, Santa Barbara, CA 93102-1200. Call with any questions or to confirm your form has been received: (805) 681-7635.