



www.cobossee.com
Josh & Jill Cohen, Directors

WINTER (Until May 15th)
17254 Gulf Pine Circle, Wellington, FL 33414
p: 800-473-6104 f: 207-933-4560

SUMMER (After May 15th)
P.O. Box 299, Monmouth, Maine 04259
p: 800-473-6104 / 207-933-4503 f: 207-933-4560

CAMPER INFORMATION FORM

To be completed by parents/guardians for all campers. One per camper.
Please fill out both sides of this form and return by **May 15th**.

Camper's Name _____ Session I Session II

Camper's Email _____ Parent/Guardian Email _____

Current Grade _____ Age _____

FAMILY INFORMATION

Parent's Marital Status: Are parents separated or divorced? Yes No If yes, when? _____

Is there any change in marital status that would be important for us to know about? Yes No

If yes, please describe _____

If yes, should there be a double mailing? Yes No If yes, please indicate a second address:

(Dr/Mr/Mrs) _____ Address _____

City _____ State _____ Zip _____

RESIDENTIAL LIFE INFORMATION

The information listed below is a tool used to help us get to know your son and take better care of him throughout his stay at Cobossee. It allows us to ensure a successful transition to camp. All of the information will be reviewed by Josh, Jill and your son's Head Counselor; any pertinent information will be shared with his cabin counselor.

1. Describe your son's personality: _____

2. How is your son feeling about camp this summer? _____

My Son...

1. Is a bed wetter? Yes No

If yes, describe: _____ Medication taken? Yes No

Procedures followed at home: _____

(OVER)

2. Has nightmares? Yes No

If yes, describe: _____

Procedures followed at home: _____

3. Is a sleep walker? Yes No

If yes, describe: _____

Procedures followed at home: _____

4. Has been under the care of a psychologist, psychiatrist or therapist in the past 2 years? Yes No

If yes, describe: _____

HEALTH INFORMATION

This information will be shared with your son's Head Counselor and is not a substitute for the completed Health Form.

1. Diet/Appetite: Good Fair Poor Overeats Undereats Lactose Intolerant*

* If yes, please describe limitations _____ Does he take medications with food? Yes No

2. Specific dietary requests / limitations: *(if related to allergies, please complete section below)* _____

3. Activities to be avoided for medical reasons: _____

4. My son takes medication:* Daily Only PRN (as needed) None Other _____

* If medications are taken, please include detailed information on Camper Medical Form.

5. Please describe any other health information to be shared with the your son's Head Counselor: _____

6. My son wears: Glasses Contacts Braces Headgear

(If your son wears glasses, please send a spare set to camp with him.)

ALLERGIES

1. My son has allergies: Yes No If yes, complete the rest of this section.

2. Food Allergies: *(please check all that apply. Please circle any that result in anaphylaxis.)* Peanuts Chocolate

Tree Nuts Dairy Shellfish Sesame Wheat Other _____

Does your child use an epipen? Yes No **If yes, please send two epipens to camp.**

3. Other Allergies: *(please check all that apply)* Environmental Bees Antibiotics Other _____

Please describe _____

PLEASE ATTACH ANY ADDITIONAL INFORMATION YOU FEEL WILL BE HELPFUL TO US.

Please return this form to us by May 15th.