Camp Watcha Wanna-Do PARTICIPANT REGISTRATION

Last Name _____ First _____

Date of Birth _____ Age at camp _____ Gender *Male* ☐ *Female* ☐

Cancer Diagnosis _____ Oncologist Name & Phone Number _____

Is this your first year attending camp? _____

How would you like to receive your medical/information packet? ☐ Email _____

☐ US Mail _____

Which would you like to register for:

☐ Camp Watcha Wanna-Do Summer Camp
Are you a: Cancer/Brain Tumor Patient ☐ or Sibling/Friend ☐

☐ Camp Watcha Wanna-Do Kinder Camp

Indicate T-shirt size *(Youth) M* ☐ *(Adult) S* ☐ *M* ☐ *L* ☐ *XL* ☐ *XXL* ☐

I am attending camp with _____ I wish to room with _____

Parent or Guardians (relationship) _____

Street Address _____ Apartment/Unit# _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Email _____

Emergency Contact _____ Phone _____

Would you like more information about how to be more involved in CWWD as a parent? *Yes* ☐ *No* ☐

Note: If your camper or any immediate family members have been exposed to a communicable disease such as chicken pox, measles, etc., within the last two weeks, please call to cancel your reservations. We do not want to expose any child to a communicable disease.

Please send completed application to:

Camp Watcha Wanna-Do
PO Box 11166
Fort Wayne, IN 46856-1166

Fax: (260) 435-2516

Reach us at (260) 609-3155