CYSTIC FIBROSIS SUPPORT NETWORK OF MI

(formerly MPDCI)

CAMP SCHOLARSHIP PROGRAM

To apply for a **CFSN** camp scholarship**,** please complete the following application in full. Incomplete applications will be returned.

A CFSN camp scholarship will be limited to an amount not to exceed $200 per person per year. Limited funding is available and will be provided on a first come, first serve basis.

Applications will be reviewed by the committee as they are received. You will be notified by email within 4 weeks of the receipt of your application.

Please be sure to sign the consent form on the following page so that we will be able to contact the camp to verify the camper's application status, and confirm with your doctor whether your child is able to participate in the camp.

Camper's Name: ______________________________

Camper's Date of Birth: ______________________________

Parent's Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

Email Address: ______________________________

Name of Cystic Fibrosis Center: ______________________________

Name of CF Doctor: ______________________________

Doctor's Phone Number: ______________________________

Camp Name: ______________________________

Camp Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

Name of Camp Director or other Contact Person: ______________________________

Camp Dates: ____________________ Camp Cost: ____________________

Please select where CFSN should send the check:

☐ Send CFSN check, **payable to the camp**, to my home address.

☐ Send CFSN check, **payable to the camp**, directly to the camp address.

Is there a date the check must be received? If so, please indicate the due date: __________

CFSN CONSENT FORM FOR CAMP SCHOLARSHIP

As part of the effort of the Cystic Fibrosis Support Network of Michigan to provide a chance for young children with CF to attend various summer camps, we may need additional information from your child's CF doctor and/or camp director.

I, ______________________________________ give permission to a CFSN representative
(parent's name)

to contact Dr. _________________________to discuss my child, ________________________
(child's doctor) (name of child)

from ______/______/______ to ______/______/______.

The expected activities in the camp are: ____

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______________________________ ______________________________
(parent's signature) (date of signature)

I, ______________________________________ give permission to a CFSN representative to
(parent's name)

contact the camp director, Mr./Mrs. _______________________ at
(name of camp director)

Camp _________________________ to discuss my child, ____________________________'s
(name of camp) (name of child)

application, fee schedule, and camp eligibility.

______________________________________ ______________________________
(parent's name) (date of signature)

Please return the completed application to:

Cystic Fibrosis Support Network
P.O. Box 650
Farmington, MI 48332

Questions may be directed to
campscholars@mpdci.org
or call 248-477-9276