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## 5th Izmir Sun, Fun and Culture Camp (ISFC-C) 2026

*July 9 - July 20, 2026*

**Organized by Izmir & Denizli  
Rotary Clubs**



*Aegean (West Anatolia) Mediterranean Coast of Turkey*





# 5th Izmir Sun, Fun and Culture Camp (ISFC-C) 2026 Part I. Organized by Izmir Rotary Club

## Day 1: July 9, Thursday

### Arrivals and Welcome to Izmir

- Transfer from the airport by host families
- Free time with host families

## Day 2: July 10, Friday

### 10:00 Meeting at District 2440 Office

(Hürriyet Bulvarı No: 4/1 D:405 Kavala Plaza Çankaya/Izmir)

- **Presentation Time:** Each participant will have 5 minutes to introduce themselves and their city/country. *(Please bring your presentation on a USB)*
- **Meeting with District 2440 Governor Rtn. Aylin Olut Ötken** and her welcome speech

**13:00** Old City Tour – Walking through Kemeraltı Open Bazaar

**14:00** Lunch at Ali Pasha Döner

**15:30** Visit to Agora Ancient City

**17:00** Seaside Walk – Promenade of Alsancak

**18:30** Studio House Alsancak Bar



## Day 3: July 11, Saturday

**10:00** Meeting at Foça Bus Stop

**11:00** Maymi Boat Tour *(Lunch included. Bring swimsuit)*

**18:30** Dinner at Gözde Pide Restaurant, Foça

**19:30** Free time in Foça

**22.30** Meeting at Bus Station for departure



## Day 4: July 12, Sunday

**11:00 – 18:00** Bueno Beach Club, Foça

**18:30 – 21:30** Open Buffet Dinner at Mark Warner Phokaia Beach Resort Hotel 5\*

**21:30 – 23:00** Tiki Bar



## Day 5: July 13, Monday

**10:00 – 13:00** Izmir Art and Culture Factory (*Meeting at World of Coffee in the garden*)

- Visit to Archeology & Ethnography, Painting & Sculpture Museums Quarter

**13:30** Ferry trip from Alsancak Pier to Bostanlı Pier

**14:30** Lunch at Kumrucu Ömür

**16:00** Free time to prepare for dinner

**19:30** Wyndham Grand Hotel, Izmir

- **Izmir Rotary Club Meeting & Dinner**
- **Flag Exchange Ceremony** (*Dress Code: Gents - long trousers and shoes; Ladies – know what they wear.*)
- **Summer Camp Party**



## Day 6: July 14, Tuesday

**11:00** Virgin Mary Visit

**12:00-17:00** Ephesus Museum & Ancient City Visit

**18.00-21.00:** Şirince Village Wine Tour & Dinner



## Day 7: July 15, Wednesday

**10:00 – 18:00:** Deep Nature Scuba Diving Center, Çeşme

Participants will receive international PADI Open Water Diver certification after completing a two-day scuba training program, followed by cultural activities and unforgettable coastal experiences in Çeşme-İzmir.

**18.30:** Dinner at Tokmak Hasan Restaurant Çeşme

**20.00:** Free Time at Çeşme Marina



## Day 8: July 16, Thursday

**10:00 – 18:00:** Deep Nature Scuba Diving Center, Çeşme

- PADI Open Water Diver Certification

**18.30:** Walking tour at Downtown Çeşme

**20.00:** Dinner



## Day 9: July 17, Friday

**11:00 – 18:00** Underwater “Ghost Net” removal activity with Rotarians

**19:00** Karaoke Night at House of X Beer House, Güzelbahçe



## 5th Izmir Sun, Fun and Culture Camp 2026 Part II. Organized by Denizli Rotary Club

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### Day 10: July 18, Saturday

**13:30** Lunch at Enver Kebap (*Traditional Denizli Cuisine*)

**15:00** City Tour – Bayramyeri Old Bazaar & Çınar District  
(Free time for shopping)

**17:00** Free time with host families

**19:00** Happy Hour at Holly Stone Pub



### Day 11: July 19, Sunday

**10:00** Visit to **Pamukkale Travertine Pools** (*UNESCO World Heritage Site since 1988*)

- Swim in the **Antique Pool (Cleopatra Pool)** (*Bring swimsuits, slippers, towels, underwater glasses, and a camera.*)
- Visit to the **Ancient City of Hierapolis** (*Founded in the 2nd century BC as a thermal spa.*)

**17:00 – 19:00** Cable Car Tour – **Bağbaşı Olive Plateau (1400m above sea level)**

**19:00 – 23:00** BBQ Party at Vadi Restaurant (*Traditional **mangal** (bbq) included.*)



### Day 11: July 20, Monday

**Farewell**

**09:30** Transfer to İzmir Adnan Menderes Airport (ADB), (Denizli – İzmir: 3.5 hour drive)



**Councelors:**

- Rtn. Ozan Karakaya (Izmir Rotary Club President) Phone: +90.533 765 12 17
- Rtn. Eda Ünlü (Denizli Rotary Club President) Phone: +90.505 578 35 58
- Rtn. Emre Poyraz (Rotary Scuba Diving Hobby Group) Phone:+90. 532 611 02 70
- Rtn. Altan Yücel (District 2440 Rotary Youth Exchange Chair) Phone:+90.532 314 61 79

• SEND ALL APP.TO:

- Rtn. M.Erdal MİSKİOĞLU (Camp Coordinator)
  - Phone: +90.532 693 76 56 , [rotaryizmir@yahoo.com](mailto:rotaryizmir@yahoo.com)
  - Address: Izmir Rotary Club / Gazi Bulvarı No:90 Çankaya İş Merkezi K:8/801  
Çankaya/Izmir/TURKIYE
- 





## TÜRKİYE

District 2440

### INVITATION TO TÜRKİYE

#### 5TH IZMIR SUN, FUN and CULTURE CAMP , TURKIYE 2026

- **Izmir Sun, Fun and Culture Camp (ISFC-C)**

*Agean (West Anatolia) Region of Türkiye*

*Aegean Sea, Mediterranean Coast*

*9th July - 20th July, 2026*

- **Arrival & Departure**

Izmir Adnan Menderes Airport (ADB)

July 9, 2026 - July 20, 2026

- **Participants:**

12 participants from all countries

(Max. 2 from the same country)

- **Age:**

18-25 years, university students

Equal number of boys and girls

#### Programme Overview:

- **First Part I. (9 days) - Izmir:**

Organized by Izmir, Rotary Club.

Includes city life, culture, history, beach activities, Scuba Diving, fun, and parties.

- **Second Part II. (2 days) - Denizli:**

Organized by Denizli Rotary Club.

Nature, ancient cities, and thermal Pamukkale experiences.

- **Theme:**

Dive into the Blue: Scuba, Sun & Culture in İzmir

- **Cost:**  
Camp fee: €960  
Includes transportation, most restaurants, boat trips, accommodation, Scuba Diving - PADI Certification (€250) All necessary diving suits and equipment will be provided by the organizing team."
- **Museums and archaeological site entries are not included.**
- You will need to cover your airfare, health insurance, and pocket Money.

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- **Language:**  
English (upper-intermediate level required for airport transit)
  - **Insurance:**  
Participants must be insured against illness, accidents, and third-party damages which also must cover scuba diving. (CISI Bolduc Plan B , One month).

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- **How to Apply**  
Complete the official **Rotary Youth Exchange Short-Term Exchange Program Camp Application Form**.  
Deadline for applications: **June 15, 2026**

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## **Participant Health Declaration – Important Information**

**To ensure the safety and well-being of all participants, we ask you to complete the following medical questionnaire carefully and honestly. Scuba diving is physically and mentally demanding activities, and certain medical conditions may increase the risk of injury or illness while diving. This questionnaire is intended as an initial screening to help identify whether medical evaluation by a physician may be necessary before participation.**



## Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

### Directions

**Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.**

**Note to women:** If you are pregnant, or attempting to become pregnant, *do not dive*.

|                                                                                                                                                                                                                                                                              |                                             |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------|
| 1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.                                                                                                                                                                          | Yes <input type="checkbox"/><br>Go to Box A | No <input type="checkbox"/> |
| 2. I am over 45 years of age.                                                                                                                                                                                                                                                | Yes <input type="checkbox"/><br>Go to Box B | No <input type="checkbox"/> |
| 3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months. | Yes <input type="checkbox"/> *              | No <input type="checkbox"/> |
| 4. I have had problems with my eyes, ears, or nasal passages/sinuses.                                                                                                                                                                                                        | Yes <input type="checkbox"/><br>Go to Box C | No <input type="checkbox"/> |
| 5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.                                                                                                                                                                         | Yes <input type="checkbox"/> *              | No <input type="checkbox"/> |
| 6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.                                                                                                                     | Yes <input type="checkbox"/><br>Go to Box D | No <input type="checkbox"/> |
| 7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability.                   | Yes <input type="checkbox"/><br>Go to Box E | No <input type="checkbox"/> |
| 8. I have had back problems, hernia, ulcers, or diabetes.                                                                                                                                                                                                                    | Yes <input type="checkbox"/><br>Go to Box F | No <input type="checkbox"/> |
| 9. I have had stomach or intestine problems, including recent diarrhea.                                                                                                                                                                                                      | Yes <input type="checkbox"/><br>Go to Box G | No <input type="checkbox"/> |
| 10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).                                                                                                                                          | Yes <input type="checkbox"/> *              | No <input type="checkbox"/> |

### Participant Signature

**If you answered NO** to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

**Participant Statement:** I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

|                                                                                                    |                                 |
|----------------------------------------------------------------------------------------------------|---------------------------------|
| _____<br>Participant Signature (or, if a minor, participant's parent/guardian signature required.) | _____<br>Date (dd/mm/yyyy)      |
| _____<br>Participant Name (Print)                                                                  | _____<br>Birthdate (dd/mm/yyyy) |
| _____<br>Instructor Name (Print)                                                                   | _____<br>Facility Name (Print)  |

**\* If you answered YES** to questions 3, 5 or 10 above **OR** to any of the questions on page 2, please read and agree to the statement above by signing and dating it **AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

**Participant Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_  
(Print) Date (dd/mm/yyyy)

**Diver Medical** | Participant Questionnaire Continued

**Box A – I have/have had:**

|                                                                                                                                                                                                     |                                |                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).                                                                                             | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.                                                             | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.                                                                                       | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| A diagnosis of COVID-19.                                                                                                                                                                            | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box B – I am over 45 years of age AND:**

|                                                                                                                                                                                                                                             |                                |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| I currently smoke or inhale nicotine by other means.                                                                                                                                                                                        | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| I have a high cholesterol level.                                                                                                                                                                                                            | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| I have high blood pressure.                                                                                                                                                                                                                 | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy). | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box C – I have/have had:**

|                                                                     |                                |                             |
|---------------------------------------------------------------------|--------------------------------|-----------------------------|
| Sinus surgery within the last 6 months.                             | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Ear disease or ear surgery, hearing loss, or problems with balance. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurrent sinusitis within the past 12 months.                      | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Eye surgery within the past 3 months.                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box D – I have/have had:**

|                                                                                              |                                |                             |
|----------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| Head injury with loss of consciousness within the past 5 years.                              | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Persistent neurologic injury or disease.                                                     | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurring migraine headaches within the past 12 months, or take medications to prevent them. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.          | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Epilepsy, seizures, or convulsions, OR take medications to prevent them.                     | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box E – I have/have had:**

|                                                                                                                               |                                |                             |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.                                  | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| An addiction to drugs or alcohol requiring treatment within the last 5 years.                                                 | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box F – I have/have had:**

|                                                                                        |                                |                             |
|----------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| Recurrent back problems in the last 6 months that limit my everyday activity.          | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Back or spinal surgery within the last 12 months.                                      | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| An uncorrected hernia that limits my physical abilities.                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

**Box G – I have had:**

|                                                                                             |                                |                             |
|---------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| Ostomy surgery and do not have medical clearance to swim or engage in physical activity.    | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Dehydration requiring medical intervention within the last 7 days.                          | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months. | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or uncontrolled ulcerative colitis or Crohn's disease.                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Bariatric surgery within the last 12 months.                                                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

## Diver Medical | Physician's Evaluation Form

Participant Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Print) Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit [uhms.org](http://uhms.org) for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

### Evaluation Result

- ☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.
- ☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

\_\_\_\_\_  
Physician's Signature Date (dd/mm/yyyy)

Physician's Name \_\_\_\_\_ Specialty \_\_\_\_\_  
(Print)

Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Physician/Clinic Stamp (optional)

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:

The Undersea & Hyperbaric Medical Society  
DAN (US)  
DAN Europe  
Hyperbaric Medicine Division, University of California, San Diego