CPC SPORTS/ART CAMP REGISTRATION

Christ Presbyterian Church
135 Whitney Ave
New Haven, CT 06510
203-777-6960

Christ Presbyterian Church in the Hill
158 Davenport Ave
New Haven, CT 06519
Pastor Anderson- 203-450-2299
Maxine Harris- 203-668-1227

Full Name: _____Date of Birth _____ Age at camp ___

Home Address: _____

Gender: ☐ Male ☐ Female

Mother/Guardian Name: _____ Phone: _____

Father/Guardian Name: _____ Phone: _____

Custodial Parent/Guardian: _____ Home Phone _____

Home Address: _____

If not available, in an emergency, notify the following people, listed in order of preference:

1. Name:_____Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone:_____
3. Name: _____ Relationship: _____ Phone: _____

☐ Camper will be picked up by: _____

☐Camper has permission to walk home with: _____

Siblings: Child #1 _____ Child #4 _____

Child #2 _____ Child #5 _____

Child #3 _____ Child #6 _____

Payment Received $ _____ by_____

Name of Camper/Staff _____ Date of Birth _____

Health History:

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

General Questions (Explain "yes" answers below)

Yes	No		Yes	No	
☐	☐	1. Have diabetes?	☐	☐	16. Ever had high blood pressure?
☐	☐	2. Have asthma	☐	☐	17. Ever been diagnosed with a heart murmur?
☐	☐	3. Have an special food restrictions? (e.g. Peanut free/Gluten free)	☐	☐	18. Ever had back problems?
☐	☐	4. Had any recent injury, illness Or infectious disease?	☐	☐	19. Ever had problems with joints (e.g.knees, ankles)?
☐	☐	5. Have a chronic or recurring illness/ condition	☐	☐	20. Have an orthodontic appliance Bring/ brought to camp?
☐	☐	6. Ever been hospitalized?	☐	☐	21. Have any skin problems (e.g. itching, rash, acne)?
☐	☐	7. Ever had surgery?	☐	☐	22. Had mononucleosis in the past 12 months?
☐	☐	8. Have frequent headaches?	☐	☐	23. Have problems with diarrhea or Constipation?
☐	☐	9. Ever had a head injury?	☐	☐	24. Have problems with sleepwalking?
☐	☐	10. Ever been knocked Unconscious?	☐	☐	25. If female, have an abnormal Menstrual history?
☐	☐	11. Wear glasses, contacts or Protective eyewear?	☐	☐	26. Have a history of bed-wetting?
☐	☐	12. Ever had frequent ear infections?			
☐	☐	13. Ever passes out during or after exercise?			
☐	☐	14. Ever been dizzy during or after exercise?			
☐	☐	15. Ever had chest pain during or after exercise?			

Please explain any "Yes" answers, noting the number of the questions.

_____

_____

_____

Use the space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Such as Special needs? Helpful suggestions to help the child to adjust to camp.

_____

_____

_____

Name of Camper/Staff _____ Date of birth _____

Allergies and Medication

Allergies: List all known and describe reaction and management of the reactions. If Epipen or asthma inhalers are needed, please be sure to send it in with child each day, labelled with their name.

Medication allergies: _____

_____

Food allergies: _____

_____

Other allergies: Include insect stings, hay fever, asthma, animal Dander, etc

_____

_____

Medications:

☐ This person takes NO medications on a routine basis.
☐ This person takes medications as follows:

Med #1: _____ Dosage _____ Frequency_____

Reason for taking_____

Med #2 _____ Dosage _____ Frequency _____

Reason for taking _____

Med #3 _____ Dosage _____ Frequency _____

Reason for taking _____

Does this person have any restrictions? ☐ YES ☐ NO

Explain any restrictions to activity (e.g. What cannot be done, what adaptations or limitations are necessary)

_____

_____

Insurance:

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

Name of Carrier or plan Name: _____

Policy number: _____

Group: _____

Preferred Hospital: ☐ YNHH Children's Hospital ☐ Yale New Haven Hospital ☐ Saint Raphael Campus

Name of Family Physician _____ Phone: _____

Address _____

Name of family dentist/orthodontics _____ Phone _____

Address _____

Medication Authorizations:

Over the counter Medications

Acetaminophen (Tylenol)
Bacitracin
Calamine lotion
Cough drops/ sore throat lozenges
Benadryl
Epinephrine for treatment of anaphylaxis (Epipen)
Hydrocortisone cream
Ibuprofen (Motrin, Advil)
Sudafed (Pseudoephedrine)

Important- Must be completed for Attendance

Parent/Guardian Authorizations;
I give permission for my child to be given the above Over the Counter medications or generic equivalent, if needed, while at camp. Doses to be administered as per package directions given by medical staff. I have crossed off any medications I do not want my child to be given.

The health history in this form is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications and emergency treatment for my child as may be necessary, including but not limited to x-ray, routine tests and treatment,and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* (in the place of a parent) if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

I hereby agree to the disclosure to camp representatives of the Protected Health information of the person here-in described, as necessary: (i) To provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off camp.

Name of Camper/Adult _____

Signature of Parent/Guardian or Adult Camper/Staff

Signature: _____

Print Name _____ Date: _____

Photo Release Permission I hereby consent to the use of photographs/videotape taken during the course of the camp for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

____ Yes, I give consent for CPC to photograph me/my child for camp purposes and/or at camp events.
____ No, I do not authorize CPC to photograph for me/my child for any event.

Parent Initial _____ Date: _____