

Camp Omega Day Camp @ St. Paul Lutheran 124 Maple St N LP, MN 55354

- July 23-27, 2018
- 9:00 AM – 3:00 PM Monday-Thursday & 9:00 AM – 12:00 PM Friday
- **Each child will need to bring his/her own lunch Mon-Thurs**
- Program for family/friends Friday @ 11:30 followed by picnic lunch (freewill donation)
- For students **ENTERING** grades 1-6
- Day Camp Registration Form with Field Trip (**One form per child**)
- Please return to St. Paul's Church ASAP
- Contact 395-2573 with questions. Thank you!

Camper Name _____ Baptized? _____

Address _____

City _____ State _____ Zip _____

Name of Parent or Guardian _____

Email Address: _____

Phone (H) _____ (W) _____ (C) _____

Birthday _____ Grade Entering _____

Home Church _____ Dates of Day Camp _____

I hereby enroll and give permission for my child to participate in the planned activities of Camp Omega Day Camp, conducted in partnership with **ST. PAUL'S LUTHERAN CHURCH (124 Maple St N, Lester Prairie, MN 55354)**. I understand I am responsible for transportation to and from Day Camp.

 SIGNATURE OF PARENT OR GUARDIAN X _____ DATE _____

I give permission and consent to allow photographs, videotapes, and interviews to be taken during the camp session. I further give consent that any such images or interviews may be published and used to illustrate and promote the camp and the National Lutheran Outdoors Ministry Association as well as St. Paul's Lutheran Church.

 SIGNATURE OF PARENT OR GUARDIAN X _____ DATE _____

Field Trip to **LP SWIMMING POOL** on **THURSDAY, JULY 26th** for all Day Camp campers. We will **WALK**, to & from the **LP SWIMMING POOL**. Certified lifeguards supervise all water activities. Understanding this situation, I hereby give permission for my child to participate in this day trip sponsored and supervised by Camp Omega and volunteers from the congregation. **Cost is \$4.00 or pool pass.**

 SIGNATURE OF PARENT OR GUARDIAN X _____ Date _____

Camp Omega Health Information Form

Camp Session Name & Date _____

Last Name _____ First Name _____ Gender M F Birthdate _____ Age _____

Name of Parent(s)/Guardian(s) (or Spouse) _____

Home Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Emergency Contact (other than parent/guardian) _____ Relationship _____

Phone Numbers: Home _____ Mobile _____ Work _____

Medical Insurance Co. _____ Policy/Certificate Number _____

Policy Holder's Name _____

Physician _____ Phone _____ Dentist _____ Phone _____

Medications Being Taken: List all medications (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period. Medications will be dispensed according to label instructions.

Medication #1 _____ Dosage _____ When taken each day _____

Medication #2 _____ Dosage _____ When taken each day _____

Medication #3 _____ Dosage _____ When taken each day _____

Date of Last Tetanus Shot _____

Health Information

General Questions (if "yes" explain below)	Yes	No
1. Has food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Must have a gluten free diet?	<input type="checkbox"/>	<input type="checkbox"/>
3. Must have a dairy free diet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is subject to fainting?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is subject to upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is subject to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a reaction to bee sting?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a reaction to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a reaction to poison ivy, oak or sumac?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a reaction to other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has had a recent injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>

General Questions continued...	Yes	No
14. Has a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
19. If female, has an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
20. Has a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
21. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
26. Has activity restrictions or limitations?	<input type="checkbox"/>	<input type="checkbox"/>

Please Attach a Copy of the Participants Immunization Records.

General Question and Explanations of Activity Restrictions or Limitations: _____

Important - This Form Must Be Signed Prior To Participation!

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby authorize the Camp Omega staff to administer medications and first aid as deemed necessary well as authorize the medical personnel selected by the camp staff to provide routine health care and emergency medical care by medical staff to hospitalize, secure treatment for, order injection, anesthesia, blood transfusions, or surgery, and to release any records necessary for insurance purposes as well as provide or arrange necessary related transportation for the above named participant. This form may be photocopied.

Photo Image Release: As a participant in a Camp Omega event, I give permission and consent to allow photos, videos, and interviews to be taken of the above mentioned individual during the camp session. I further give consent that any such images or interviews may be published in a variety of ways and used to illustrate and promote Camp Omega and the National Lutheran Outdoors Ministry Association.

★ **Signature** of parent/guardian or adult guest/staff _____ **Date** _____

For Camp Use - In-Camp Health Screening Record Date of screening _____ Time _____ Conducted by _____

Meds Received at Screening _____

Updates / Additions to health history noted [] Yes [] No [] None Required

Current Health Needs Identified _____

Observational Notes _____