PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Side 1 of 2

Churches of Christ in Christian Union

# Summer Camp Registration

Please **PRINT** and carefully complete this form. Only one camper per form. Payment of the entire camp fee is required with this registration. Refunds are permitted up to one week prior to the start of each camp.

## Section 1: Camp Selection

Please check for which camp you are registering. (Select only one)

☐ SCD Junior Camp ☐ SCD Junior High Camp ☐ SCD Teens In Action

## Section 2: Camper Information

Camper's Name _____ Gender: ☐Male ☐Female

Address _____ Phone_____

City_____ State _____ Zip _____ Date of Birth_____

Age at time of camp _____ E-mail _____

Home Church _____ Denomination _____

School _____ Grade Completed _____

Parent/Guardian Name 1. _____ Phone _____

Parent/Guardian Name 2. _____ Phone _____

Roommate Request 1. _____ 2. _____ T-shirt Size _____

## Section 3: Camper Pledge

I promise to attend all activities and services, unless officially excused, to obey all the rules of the camp and the grounds, and to conduct myself as a lady/gentleman at all times.

Camper Signature _____ Date _____

PLEASE TURN OVER AND COMPLETE SIDE TWO

**CAMP REGISTRAR USE ONLY**

Fee Paid _____ Check # _____ Room # _____ Team # _____

**TO BE COMPLETED ON DAY OF DEPARTURE ONLY**

Picked up by: _____ Date _____ Time _____

PLEASE COMPLETE THE FRONT SIDE OF THIS FORM

Side 2 of 2

# Medical Information & Release

The information below is necessary for the camp nurse and/or coordinators to adequately treat your child in the event of an injury or illness. All information will remain confidential.

## Section 4: Personal Information

Camper's Name _____ Date of Birth _____

Family Physician _____ Phone _____

Insurance Company _____Policy/ID _____

## Section 5: Medical History

Is this child up to date on all immunizations? ☐Yes ☐No Date of last tetanus booster _____

Medications your child is currently taking: _____

**All medications must be turned in to the camp nurse at check-in. Medications must be in their original container with the patients name and the name of the medication on the bottle.**

Allergies:_____

Is this child able to participate in strenuous activities such as swimming and athletics? ☐Yes ☐No

Chronic or existing illnesses, past medical treatments or other current medical conditions:

_____

## Section 6: Emergency Contact

Name _____ Phone #1_____ Phone #2_____

Name _____ Phone #1_____ Phone #2_____

## Section 7: Parental Release

I understand that my child is under the supervision of quality leadership while attending camp. However, I also understand that my child will be participating in activities that could cause possible injury, such as swimming, sports, canoeing or construction projects depending upon the camp he/she is attending. I understand that great care is taken to ensure the safety of my child but that some of the activities may be dangerous by nature. Therefore; I release the camp and its governing board(s) as liable or responsible for injuries in the event of a lawsuit. I also give permission for my child to be transported off campgrounds for participation in camp activities. Furthermore, I authorize the Camp Coordinator, Assistant Coordinator, Camp Nurse, or any other official they deem appropriate to seek any necessary examination, treatment and/or hospital care for the camper named above under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio. **I grant permission for photographs to be taken of my child for camp directories and for publicity use**.

Parent/Guardian Signature _____ Date _____

If I am unable to pick my child up, I give _____ permission to bring my child home.

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

**General Health History**: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

| | | | | | |
|---|---|---|---|---|---|
| 1. Ever been hospitalized? | ☐ Yes | ☐ No | 11. Had fainting or dizziness? | ☐ Yes | ☐ No |
| 2. Ever had surgery? | ☐ Yes | ☐ No | 12. Passed out/had chest pain during exercise? | ☐ Yes | ☐ No |
| 3. Have recurrent/chronic illnesses? | ☐ Yes | ☐ No | 13. Had mononucleosis ("mono") during the past 12 months? | ☐ Yes | ☐ No |
| 4. Had a recent infectious disease? | ☐ Yes | ☐ No | 14. If female, have problems with periods/menstruation? | ☐ Yes | ☐ No |
| 5. Had a recent injury? | ☐ Yes | ☐ No | 15. Have problems with falling asleep/sleepwalking? | ☐ Yes | ☐ No |
| 6. Had asthma/wheezing/shortness of breath? | ☐ Yes | ☐ No | 16. Ever had back/joint problems? | ☐ Yes | ☐ No |
| 7. Have diabetes? | ☐ Yes | ☐ No | 17. Have a history of bedwetting? | ☐ Yes | ☐ No |
| 8. Had seizures? | ☐ Yes | ☐ No | 18. Have problems with diarrhea/constipation? | ☐ Yes | ☐ No |
| 9. Had headaches? | ☐ Yes | ☐ No | 19. Have any skin problems? | ☐ Yes | ☐ No |
| 10. Wear glasses, contacts, or protective eyewear? | ☐ Yes | ☐ No | 20. Traveled outside the country in the past 9 months? | ☐ Yes | ☐ No |

***Please explain "Yes" answers in the space below,*** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health**: ***Check "Yes" or "No" for each statement.***

Has the camper:

| | | |
|---|---|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | ☐ Yes | ☐ No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | ☐ Yes | ☐ No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | ☐ Yes | ☐ No |
| 4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | ☐ Yes | ☐ No |

***Please explain "Yes" answers in the space below,*** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers**:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s):_____ Phone: (_____) _____

Name of orthodontist(s):_____ Phone: (_____) _____

**What Have We Forgotten to Ask?** ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

***Mail this form to the address below by _____ (date)***

1553 Lancaster Pike
Circleville, OH 43113

***To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.***

1) ***Complete pages 1 and 2 of this form (FORM 1) and make a copy .***
2) ***Send the original, signed FORM 1 to camp by the requested date.***

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

**Medication:** ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

| Name of medication | Date started | Reason for taking it | When it is given | Amount or dose given | How it is given |
|---|---|---|---|---|---|
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____ | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____ | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____ | | |

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis
***Cross out those the camper should not*** take to manage illness and injury.

Acetaminophen (Tylenol)
Sore throat spray
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Ibuprofen (Advil, Motrin)
Generic cough drops
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Aloe
Antibiotic cream

**Parent/Guardian Authorization for Health Care:**

**This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child forboth routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.**

Signature of Custodial Parent/Guardian _____ Date: Relationship to Camper: _____

Camper Name First Middle Last (For Camp Use) Cabin or Group (For Camp Use) Session Code(s):