

# 2015 Kids' Camper Application: Let God

Camper's Name: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_ Gender:  M  F Grade completed: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Church Name: Praise Assembly City: Newark, DE

## Please mark appropriate week:

- Week #1: July 6-10
- Week #2: July 13-17
- Week #3: July 20-24
- Week #4: July 27-31

## Today's Payment:

- \$50 Camp Deposit
- \$204 Camp Full Payment
- \$15 Camp DVD (interactive countdowns, games, & photos)
- Extra Spending Money (Prepaid Amount: \$\_\_\_\_\_) (Please use increments of \$5.)
- Free T-shirt (please circle size below)  
(S M L XL XXL XXXL - Adult Sizes)

Please turn in the completed camper application with deposit to your church group leader. Incomplete applications will be charged \$10.

## INSURANCE INFORMATION - CHILDREN MUST HAVE INSURANCE COVERAGE IN ORDER TO ATTEND.

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

If so, indicate the carrier or plan name: \_\_\_\_\_ Group # \_\_\_\_\_

Family Physician/Pediatrician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

## PARENTAL CONSENT AND MEDICAL AUTHORIZATION

This camper application and health history 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-rays, routine tests and treatment and/or hospitalization. I agree to release any records necessary for treatment, referral, billing or insurance purposes. It is my intention that the camp be treated as acting in *loco parentis* 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 purpose of disclosing information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I also consent to photographs and/or video images of the above listed camper for use within the scope of PennDel Ministry Network advertisements and brochures.

I acknowledge that participation in the activity named above involves risk to the participant (and to the participant's parents/guardians, if the participant is a minor), and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage, and financial damage. In consideration for the opportunity to participate in the activity named above (the "activity") the participant (or parent/guardian if the participant is a minor) acknowledges and accepts the risks of injury associated with participation. The participant (or parent/guardian) accepts personal financial responsibility for any injury or other loss sustained during the activity, as well as for any medical treatment rendered to the participant that is authorized by the sponsor or its agents, employees, volunteers, or any other representatives (collectively referred to as the "activity sponsor"). Further, the participant (or parent/guardian) releases and promises to indemnify, defend, and hold harmless the activity sponsor for any injury arising directly or indirectly out of the described activity or transportation to and from the activity, whether such injury arises out of the negligence of the activity sponsor, the participant, or otherwise. If a dispute over this agreement or any claim for damages arises, the participant (or parent/guardian) agrees to resolve the matter through a mutually acceptable alternative dispute resolution process. If the participant (or parent/guardian) and the activity sponsor cannot agree upon such a process, the dispute will be submitted to a three-member arbitration panel for resolution in accordance with the rules of the American Arbitration Association.

Parent/Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY: Please complete health history on the reverse side. Incomplete applications will be charged \$10.

The following information must be filled in by the parent/guardian. The intent of this information is to provide the camp health care personnel with the background to administer appropriate care. Keep a copy of the completed form for your records. This information will be included on the Medical Update form and given to the camp staff at the time of registration. Provide complete information so that the camp can be aware of your child's needs.

Camper Name: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_  Unsure of exact date  All immunizations are current

**Medication Allergies**

Describe reaction and management of the reaction.

\_\_\_\_\_  
\_\_\_\_\_

**Food Allergies** - Please list any medical food allergies. If your child has medical dietary needs, please call (717) 243-7381 or e-mail [ajurado@bongiornocc.com](mailto:ajurado@bongiornocc.com) and speak with Albert Jurado, Food Service Director. We are ***not*** a peanut free facility. While we do not intentionally use peanuts or peanut products, some foods may be processed in facilities that handle peanuts or peanut products.

\_\_\_\_\_  
\_\_\_\_\_

**Other Allergies** - Include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN**

This person takes **NO medications** on a routine basis.

Our Medical Personnel can only dispense medications in the **original packaging/bottle** that identifies the **prescribing physician** (if a prescription drug), the **name of the medication**, and the **dosage and frequency of administration**. Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) that are taken routinely. Send enough medication to last the entire week of camp, no more, no less, in the **original packaging/bottle**.

This person takes medications as follows:

Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Taken:  Breakfast  Lunch  Dinner  Bedtime

Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Taken:  Breakfast  Lunch  Dinner  Bedtime

Reason for taking: \_\_\_\_\_

Med #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Taken:  Breakfast  Lunch  Dinner  Bedtime

Reason for taking: \_\_\_\_\_

(Attach additional pages for more medications.)

I give permission for the on-site medical personnel to administer the following medications to my child when necessary:

Tylenol (Acetaminophen)  Advil (Ibuprofen)  Benadryl (Diphenhydramine)

**RESTRICTIONS:** The following dietary restrictions apply to this individual:

Does not eat meat.  Does not eat eggs.  Does not eat dairy products.  Other: \_\_\_\_\_

Explain any physical restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary):

\_\_\_\_\_  
\_\_\_\_\_

**Bed Wetting**  Yes  No **Bed Wetting Precautions taken:** \_\_\_\_\_