

2008 KNYI Sr. High Camp

June 2-6, 2008

Camper Registration & Health Form

Golden Bell Camp & Conference Center

Camper's Name _____ Birth date _____ Sex _____ Age _____

Address _____

Phone _____ E-Mail _____

Local Church _____ T-Shirt Size: _____

1. Parent /Guardian _____

Address (If different than above) _____

Employer _____ Work Address _____

Phone: Home _____ Work _____ Cell _____

2. Parent/Guardian _____

Address (If different than above) _____

Employer _____ Work Address _____

Phone: Home _____ Work _____ Cell _____

*Parent/Guardian info must be complete.

Parent or Guardian Authorization: This is required for participation.

All information on this form is correct and complete. I give permission for my child to participate in all on or off site camp activities, including transportation, except as noted, to be provided routine health care, and to be given medication authorized by my child's health care provider or the licensed medical provider selected by the camp. I give permission to the physician selected by the camp to order x-rays, routine tests and treatment for the health of my child. 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 my child. I also give permission for my child's photo to be used in future promotional materials, brochures and videos. I agree to hold harmless for loss or damage and agree not to sue or bring any action whatsoever against Golden Bell Camp & Conference Center, its agents, servants, & employees on account of injury to my child while participating in camp activities. I am fully aware of the inherent hazards and risks involved in camp activities, and assume all risks of loss or injury. I understand that Golden Bell provides secondary insurance only, and that Golden Bell is not responsible for personal belongings brought to camp.

Signature _____

signed

printed

date

Please fill out completely – if something does not apply to your child, please fill in N/A

Health History: (check - giving approximate dates)

*ADD/ADHD _____	Ear infections _____	Measles _____	<u>Allergies:</u>
*Eating disorders _____	Respiratory illness _____	Mumps _____	Hay fever _____
*Headaches _____	Strep throat _____	German measles _____	Ivy poisoning, etc. _____
*Asthma _____	Rheumatic fever _____	Chicken pox _____	*Insect stings _____
*Seizures _____	Mononucleosis _____	*Dental problems _____	*Penicillin _____
*Diabetes _____	Hepatitis _____	Glasses / contacts _____	*Food _____
			*Other _____

Please provide further information, especially on starred items above: _____

Operations or serious injuries (with dates please): _____

Chronic or recurring illness: _____

Has camper ever consulted a physician, psychiatrist or psychologist concerning an emotional problem; or is there a behavioral or emotional trait the camp or staff should be aware of? Yes _____ No _____

Please explain _____

Any specific activities to be restricted for health reasons? _____

Please notify camp if your child is exposed to any communicable disease during the 2 weeks prior to camp.

Immunization History: This is a record of dates of basic immunizations and most recent boosters:

DPT Series _____	Tetanus/diphtheria booster _____
Mumps _____	Polio _____
Measles (live) _____	Varicella (chicken pox) _____
German measles (Rubella) _____	Hepatitis B _____
Tuberculin test _____ Result _____	Hepatitis A _____
BCG _____	Haemophilus influenza B _____

Medical Examination – To be completed by licensed medical personnel

This examination should be performed within 24 months of arrival at camp.

** Examination for some other purpose within this period is acceptable.**

Please identify any medications taken during the school year but not at camp _____

Height _____	Weight _____	B.P. _____	Hgb test _____	Urinalysis _____
Eyes _____	Heart _____	Lungs _____	Posture _____	Skin _____
Ears _____	Abdomen _____	Hernia _____	Allergy – please specify _____	
Nose _____	Teeth _____	Extremities _____		

General Appraisal: _____

Does the camper have any significant condition of which a health care provider should be aware?

Medical condition _____ Physical Condition _____ Emotional Condition _____

Please explain: _____

For females: Has this person menstruated? _____ If so, is her menstrual history normal? _____

Medications: Please list all prescriptions and over-the-counter medications you authorize.

Medications need to be given to the nurse upon arrival at camp. Please pack separately.

All prescription and over the counter medications **MUST** be in their original containers.

The prescription meds must have correct name of camper, dosage information, the prescribing doctor's name and pharmacy information.

Over the counter medications **MUST** have a doctor note with it for its use.

_____ medication _____ dosage/route/frequency _____

_____ medication _____ dosage/route/frequency _____

If necessary, please attach a separate sheet with any additional medications.

Restrictions while in camp: Is there any condition you feel would prevent this camper from carrying on strenuous physical activity at an altitude of 9000' and above, or are there any limitations you would place on his/her activity? _____ If yes, please comment: _____

Special diet: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that this camper is physically able to engage in all camp activities except as noted above.

_____ signed _____ date _____ printed name _____

Telephone _____ Address _____

Date of exam _____

Insurance Information

I have no insurance. _____

Primary Insurance:

Medical Insurance Company

Policy & Group Numbers

Address & Phone

Secondary Insurance:

Medical Insurance Company

Policy & Group Numbers

Address & Phone

***Please be sure to attach a photocopy of your insurance card/cards.
Camper is responsible for insurance protection.***