



# 2008 Kid's Camp Individual Application

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_ Gender: M F Grade completing: \_\_\_\_

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

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

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

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

Church Name: \_\_\_\_\_ City: \_\_\_\_\_

**Please mark appropriate weekend:**

- Weekend #1: July 7-11
- Weekend #2: July 14-18
- Weekend #3: July 21-24
- Weekend #4: July 28-August 1

**Today's Payment:**

- \$50 Camp Deposit
- \$170 Camp Full Payment
- T-shirt (please circle size below)  
(S M L XL XXL XXXL - Adult Sizes)

Deposit must be made when registering the camper. No individual registrations are accepted. Please turn in the completed camper application to your church group leader. Churches: please remit one check for all campers and chaperones. Make payable to: PennDel.

### INSURANCE INFORMATION

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 also give permission for the camp to arrange related transportation. 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 hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein 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 the event that I cannot be reached in an emergency, I hereby give permission to the Registered Nurse/Physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

In addition, 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.

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

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

**HEALTH HISTORY**

The following information must be filled in by the parent/guardian. The intent of this information is to provide the camp health care personnel the background to administer appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to your church's group leader prior to departure for camp. 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.

**ALLERGIES.** List all known.

**Medication Allergies**

**Describe reaction and management of the reaction.**

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

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

**Food Allergies** - please contact your church group director if there is a need of a specific food regimen because of a medical condition. We want and need to have a clear understanding of the individual's dietary needs.

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

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

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

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

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

**MEDICATIONS BEING TAKEN**

Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) that are taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

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

This person takes medications as follows:

Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken each day: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken each day: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Med #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken each day: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Attach additional pages for more medications.

**RESTRICTIONS**

The following restrictions apply to this individual.

**Dietary**

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

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

\_\_\_\_\_

**Bed Wetting**     Yes     No    **Bed Wetting Precautions:** \_\_\_\_\_    **Date of last tetanus shot:** \_\_\_\_\_

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

Tylenol(Acetaminophen)     Advil (Ibuprofen)     Benedryl (Diphenhydramine)