

# 2009 Camp Perkins Day Camp Registration, Health, and Release Form

**This form must be on file with Camp Perkins prior to participation in any programming.**

Participant Last Name \_\_\_\_\_ First Name \_\_\_\_\_ T-Shirt Size \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Gender: M ( ) F ( ) Height \_\_\_\_\_ feet \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs Grade Entering in Fall of 2009 \_\_\_\_\_ Home Church \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Mother's Full Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Lives with participant? **Yes No**  
 Father's Full Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Lives with participant? **Yes No**  
 Emergency Contact Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_  
 Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ In case of emergency, whom should we call first? \_\_\_\_\_

**Pick-up Authorization:** Please list all individuals, including siblings who are authorized to pick up this individual from day camp. If the individual is not listed, the primary emergency contact listed above will be called to authorize the pick-up of the camper. If they will be walking or riding a bike home, please check the appropriate box below.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Allowed to check self out and walk or ride bike home? **Yes No**

**Current Medications:** Please note, all prescription medications MUST be prescribed to this individual. All medications brought must current and be in their original packaging.

Name of Medication	Reason for Taking	Dosage	Schedule

## Health History

Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:
Anxiety or Depression	No Yes	Current Past	Recurrent Headaches	No Yes	Current Past	Heart Disease or Problems	No Yes	Current Past	Diabetes	No Yes	Current Past	ADD or ADHD	No Yes	Current Past
Epilepsy or Convulsions	No Yes	Current Past	Disease or injury to joints or back	No Yes	Current Past	Frequent Colds	No Yes	Current Past	Dizzy Spells or Fainting	No Yes	Current Past	Asthma	No Yes	Current Past
	No Yes	Current Past	Comments, other issues, physical limitations and/or list surgeries											

## Allergies/Dietary Needs

Type of Allergy	Circle One	Describe/Specify Allergen	Mild (Runny Nose, sneezing)	Moderate (Swelling or severe rash)	Severe (Systemic Response/Difficulty breathing)
Food	No Yes				
Medication	No Yes				
Environmental (animal, plant, insect, etc.)	No Yes				
Other	No Yes				

Vegetarian? No Yes Limitations: \_\_\_\_\_ Gluten Allergy? No Yes Limitations: \_\_\_\_\_ Lactose Intolerant? No Yes Limitations: \_\_\_\_\_

**Medical Insurance:** Does this person you have medical insurance? **IF YES**, please attach a copy of both the front and back of your health insurance card.  
**Yes No** **IF NO**, please attach a signed letter stating that you agree to pay for any medical costs in the event of an emergency. These costs are not in any way covered by Camp Perkins.

## Authorization

I hereby give informed and expressed consent for this individual to take part in all camp activities under supervision, and agree that the camp or camp personnel will not be held responsible for accidents arising there from. I authorize the camp staff to provide appropriate treatment to this individual for injuries and/or illness. This includes, but is not limited to, following Camp Perkins medical procedures and protocols, following poison control recommendations, administering prescription medications as noted above, administering over the counter medications as listed above, transportation to clinic or hospital care, and following directions from the medical director. I understand that the information on this form may be released to the appropriate medical personnel in case of emergency. I agree to pay any cost for medical care in the event of an emergency, even if I do not have health insurance coverage or if not all costs are covered by insurance. I also understand that failure to disclose medical or emotional problems in advance may lead to serious consequences while at camp. Lastly, I verify that everything contained on this form is complete and accurate, to the best of my knowledge.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_