Camper Registration Form - 2017

PLEASE NOTE: Camp registration and payment may now be done online at the following website address: abcin.campmanagment.com/enroll

Parent/Guardian: Please print or type all information clearly. The entire registration and medical form must be completed and signed in order to register for camp.

Camp Attending: ☐ Indian Creek ☐ Tippe	ecanoe					
Camp Session	_ Date of Camp					
Camper's Name	Birth DateAge					
□ Male □ Female Grade Completed	Camper Email					
Name of person you desire to be housed with						
T-Shirt Size (circle one) Y-S Y-M Y-L A-S A-M A-L	. A-XL A-XXL A-XXXL					
Attending Church	Pastor					
Church AddressC	ity State Zip					
Custodial Parent/ Guardian	·····					
AddressCity_	StateZip					
Preferred Phone 1. ()	2. ()					
Parent Email						
PLEASE NOTE: There will be a late fee of \$25.00 if payment Make check payable to ABC-IN/KY	is not postmarked 10 days prior to start of camp session Line 1: Camp session fee (1)					
There is a \$50.00 cancellation fee. Send registration, health form and check to:	Line 2: Family discount (2)(Subtract \$10.00 for each additional camper from the same family-not including first child registered)					
Camp Registrar	Line 3: \$25.00 late fee, if applicable (3)					
ABC-IN/KY 1350 N Delaware St	Line 4: Subtotal (add lines 1-3) (4)					
Indianapolis IN 46202	Line 5: Enter amount paid with registration (5)					
If you need to make payment arrangements, contact the camp registrar:	Line 6: Subtract line 5 from line 4 and (6)enter balance due.					
Kristie Dowdy	Please indicate who will pay balance:					
kristiedowdy@abc-indiana.org (317) 635-3552 ext 228	□Parent □Church					
For Office Use Only						
Date Rec'd CK No Amt Date Rec'd CK No Amt						
Date Net uCN INUAMIL_						

HEALTH HISTORY FORM

The following information must be filled out by the parent/guardian, or adult camper, or staff member. The intent is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health care personnel upon camper's arrival at camp. Provide complete information so that the camp can be aware of the camper's needs. Camp Session _____ Dates attending ___ Month/Dav/Year Month/Day/Year Camper Name: First Last Birth Date: _ Age on arrival at camp: ____ ☐ Male ☐ Female Month/Day/Year Camper Home Address: Street Address City Zip Code Parent/Guardian with legal custody to be contacted in case of illness or injury: Relationship Preferred Phones (Home Address: (if different from above) Street Address Zip Code Second parent/guardian or other emergency contact: Relationship to Camper: Preferred Phones () __ Additional contact in event parent(s) cannot be reached: Relationship ____()____ Preferred Phones (**Date of last Physical Exam**_____. The camper must have had a physical exam within the last year. **Healthcare Providers:** Name of camper's primary doctor Office phone Name of family dentist/orthodontist Office Phone **Medical Insurance Information:** Please include (Your child will not be admitted without this information) a copy of the Is the camper covered by family medical/hospitalization insurance?

Yes

No insurance card Carrier or plan name (front & back) or bring card to Group No. check-in. Name of Insured Relationship to camper Parent/Guardian Authorization for Health Care: I hereby give permission to the medical personnel selected by the camp manager to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp manager to secure and administer treatment, including hospitalization for the camper named above. I also give permission to the camp medical staff selected by the camp manager to review the medical information enclosed in this document. This complete form may also be photocopied for trips outside of camp grounds. By signing you are also stating the following: The health history is correct and complete as far as I know. The camper named above has permission to engage in all camp activities except noted elsewhere on this form. Your child will not be admitted without your signature. Parent/Guardian Signature Parent/Guardian Signature

Photographs:

I give my permission for photos, videos, and quotations of the above camper to be procured by the camp, and used in perpetuity for advertisement, media, social media, and promotion of all kinds.

Allergies: ☐ No known allergies. This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other (Please describe below what the camper is allergic to and the reaction seen.)										
<u>Diet, Nutrition</u> : □ This camper eats a regular diet. □ This camper eats a regular vegetarian diet. □ This camper has special food needs. (Please describe below.)										
Restrictions: □ I feel the camper can participate without restrictions. □ I feel the camper can participate with the following restrictions or adaptations. (Please describe below.)										
Medication: ☐ This camper will not ☐ This camper will tak										
List all medications taken routinel camp session. All medications must name of the medication, the dosage,	be in the original packa	ging/bottle that ide	entifies the pre-	scribing p	hysician (if a	prescription dr	ug), name of tl	ne camper,		
Name of medication	Date Started	Reason for taking it		When	it is given	Amount or do	se How	How it is given		
				□Breakfast □Lunch □Dinner □Bedtime □Other time:						
				□Breakfast □Lunch □Dinner □Bedtime □Other time:						
				□Breakfast □Lunch □Dinner □Bedtime □Other time:						
	Questions to explain Yes answ	vers)		In	nmunizatio	on Dates (re	equired)			
(use additional sheet to explain Yes answers) Has/Does the camper: Yes No Has the camper had a TB test? □ Yes □ No										
Had any recent surgery, illness or infectious disease?			If yes, date of last test:							
Have a chronic recurring illness or co	Result:	Result: ☐ Positive ☐ Negative								
Ever been hospitalized?						- -				
Ever had surgery?				_	Date	Date	Date	Date		
Have frequent headaches?			Vaccine		Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr		
Wear glasses, contact, or positive eye wear?		Tetanus								
Have a history of bed-wetting?		Polio								
Have a problem with sleepwalking?		MMR								
If female, have abnormal menstrual history?		Or Me	asles							
			Or Mu	mps						
Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.		Or Rul	oella							
Has the camper:			Hepatitis	s B						
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? □ Yes □ No		Varicella (Chicker								
2. Ever been treated for emotiona	i oi penavioral diπicultie	s or an eating	L					_		

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