2024 Mid-America Disciples Faith Adventures Camp Registration and Health History

Forms and More Information Online: (www.faithadventurescamp.com)

Complete a separate registration form for each camper – return form to your Disciples congregation or to Registrar listed on back

CAMP NAME: FAITH ADVENTURES CAMP **CAMP DATES: JULY 22– JULY 26 (TRY IT JULY 25-JULY 26)**

CAMP GROUP: ___*TRY IT (COMPLETED K-2ND) ___JYF (COMPLETED 3RD-5TH) ___CHIRHO (COMPLETED 6TH-8TH) ___CYF (COMPLETED 9TH-12TH)

***AN ADULT MUST ACCOMPANY TRY IT CAMPER**

Camper T-Shirt Size (circle one): Youth S Youth M Adult S Adult M Adult L Adult XL Adult 2XL Adult 3XL

Try It Adult Sponsor T-Shirt Size (circle one): Adult S Adult M Adult L Adult XL Adult 2XL Adult 3XL

Check Yes/No: First Time Camper? Yes □ No □ Does Participant Swim? Yes □ No □

List any Person(s) NOT ALLOWED to pick up your child from camp/event: _____

Reason: _____

Camper cabin-mate request (1 name only/must be mutual): _____

Participant Name: _____ Date of Birth _____

Gender: _____ Age: _____ Grade (2023 - 2024 school year): _____ YR of HS Graduation: _____

Participant Address: _____City/State/Zip: _____

Home Phone: ( ) _____ Participant Cell Phone: ( ) _____ Participant Email: _____

Local (DOC) Congregation & City: _____ Pastor's Name:_____

Church or Pastor's Email Address: _____

Mother/Guardian's Name: _____ E-mail: _____

Complete Address (if different from Participant): _____

Daytime Phone: ( ) _____ Cell/Other Phone: ( ) _____

Father/Guardian's Name: _____ E-mail: _____

Complete Address (if different from Participant): _____

Daytime Phone: ( ) _____ Cell/Other Phone: ( ) _____

If Parents/Guardians are unavailable in emergency, notify (name): _____

Relationship to Participant: _____ Daytime Phone: ( )_____ Cell/Other Phone: ( )_____

***(For K-2 Try It Campers only)** Adult Sponsor's Name: _____ Address: _____

Gender: ____ Date of Birth: _____ Relationship to Try It Camper _____Health Ins. Company and Policy # _____

Emergency Contact / Number: _____ Known Allergies or Medications:_____

Adult Try It Sponsor's Signature X_____ **Date** _____

Releases and Authorizations: ***please check to be sure all signatures (3) and initials (3) are completed below.***

This Registration & Health History is correct and complete as far as I know. The person herein named as "participant" has permission to engage in all activities except as noted. I hereby give permission to event leaders to provide, seek, and consent to routine health or dental care, administration of prescribed medication, and emergency treatment for me/my child, as may be deemed necessary, including but not limited to x-rays, routine tests, and treatment, and/or hospitalization. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that event leaders be treated as acting *in loco parentis* if the person herein named is a minor. Further it is my intention that the appropriate event representatives be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the Health Insurance Portability and Accountability act of 1996. I hereby agree (pursuant to 45CFR§164.510(b)) to the disclosure to these representatives of the protected health information of the person herein described, as necessary; (1) to provide relevant information to event representatives related to the person's ability to participate in activities; and (2) in the case of minors, relevant information to event representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by event leaders to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Please initial Medication, Transportation and Photography Releases:

1. _____ We/I authorize staff to administer over-the-counter medication to my child for minor pain, headache, upset stomach, sore throat, cold symptoms, or allergy.
2. _____ We/I give permission for our/my child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Mid-America Disciples (DOC) Summer Ministry.
3. _____We/I give permission for our/my child to be photographed, video or audio taped and understand that these photos, videos, or recordings may be used in Mid-America of the Christian church (DOC) newsletters, promotion or other print, digital or internet publications.

Signature of Custodial Parent/Guardian (or Adult Camper/Staff) X _____

Printed Name_____**Date**_____

Participant Covenant: I covenant with my Creator, event staff, and other participants to do my best to:

*Expect the best of others, and give my best in our activities together.
*Participate fully in activities and attend the entire event.
*Abide by rules, policies, and expectations of the camp/event.
*Expect to make new friends, be a friend to others, and have fun.
*Respect event property and personal belongs of participants and staff.
*Respect each person's dignity, affirming that each one is created VERY GOOD, in the image of God.
*Be a good steward of creation, appreciating and caring for the environment.
*Grow in my relationship with Jesus Christ, through prayer, Bible study, worship and fellowship.
*Create a community of hospitality and inclusion that honors the unique contributions of each person.

Participant's Signature X _____**Date** _____

Pastor's Recommendation: I recommend this individual for participation in Mid-America Disciples (DOC) Summer Ministry.

Pastor's Signature X _____ **Date** _____

For Office Use Only: ___ Spreadsheet ___ Active ___ Copied ___ Added to Church Ledger ___Insurance Card

Health History for (Participant Name):_____ **Date of Last Physical Exam:**_____

Insurance Information: Is the participant covered by medical /hospital insurance □ Yes □ No **Date of Last Tetanus** _____

If so, list carrier or plan name: _____ Policy/Group #: _____

Physician: _____ Phone: ( )_____

Dentist/Orthodontist: _____ Phone: ( )_____

ALLERGIES List all known Include medicines, food, insect stings or bites, hay fever, asthma, animal, etc.	**Describe reaction and management of reaction** If more space is needed, please attach an additional sheet

DIET, NUTRITION: ☐This participant eats a regular diet. ☐This participant eats regular vegetarian diet. ☐This participant has special food needs. Please describe any special dietary needs below. If additional space is needed, please attach an additional sheet.

MEDICATIONS BEING TAKEN Please list all medication (including over-the-counter or non-prescription drugs)
Bring enough medication to last entire camp/event. All medication must be in the original package that identifies the patient, prescribing physician (if prescription drug), name of the medicine, dosage and frequency of administration. If more space is needed, please attach an additional sheet.

Medication & Dosage.	**When given & reason for taking medication**

Camper Height_____ **Camper Weight**_____

General Health: Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet if needed. For travel outside country, please name countries visited.

	Has or does the participant:	YES	NO		**Has or does the participant:**	YES	NO
1.	Had a recent injury, illness or infectious disease?	☐	☐	11.	Have asthma/wheezing/shortness of breath?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐	12.	Ever had back/joint problems?	☐	☐
3.	Ever been hospitalized?	☐	☐	13.	Have any skin problems (e.g. itching, rash, acne)?	☐	☐
4.	Ever had surgery?	☐	☐	14.	Had mononucleosis (“mono”) in the past 12 months?	☐	☐
5.	Issues regarding gender identity?	☐	☐	15.	Had problems with diarrhea/constipation?	☐	☐
6.	Ever had a head injury?	☐	☐	16.	Have problems with falling asleep/sleepwalking?	☐	☐
7.	Had fainting or dizziness?	☐	☐	17.	If female, have problems with periods/menstruation?	☐	☐
8.	Ever had seizures or convulsions?	☐	☐	18.	Have a history of bedwetting?	☐	☐
9.	Ever passed out/had chest pain during or after exercise?	☐	☐	19.	Wear glasses, contacts, or protective eyewear?	☐	☐
10.	Have diabetes?	☐	☐	20.	Traveled outside the country in the past 9 months?	☐	☐

_____

_____

_____

Mental, Emotional and Social Health Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet if needed.

	Has the participant:	YES	NO
1.	Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐	☐
2.	Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐	☐
3.	During the past 12 months, seen a professional to address mental/emotional health concerns?	☐	☐
4.	Had a significant life event that continues to affect the camper’s life? (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other…)	☐	☐

_____

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What have we forgotten to ask? Use this space to provide any additional information about the participant’s health or behavior that you think important or that may affect his/her ability to participate fully in the camp/event. If more space is needed, please attach an additional sheet.

Return completed, signed form with the 2 items to your local church, if Disciples. *All others, return items to:*
Faith Adventures Camp Registrar, Kim Houser, 23975 County Road 255, Pittsburg, MO 65724 or email khouser1110@gmail.com
1) Copy of front and back of insurance card 2) Payment of fee - make check out to your local church