



# Mid-America Disciples & Missouri Union Presbytery Summer Ministries Registration and Health History

## NEOLA CAMPS at Jo-Ota *Complete a separate registration form for each event*

Please Select a camp week (all grade levels are those just completed): Elem/Junior (2nd-5th Grades July 7-11 \*\*Elem Camp Leaves late afternoon of 9th\*\* ) \_\_\_  
CYF (9th 12th Grade July 13-18 ) \_\_\_ Chi-Rho(6th-7th Grades July 20-25 ) \_\_\_

Camper Name (Last,First) \_\_\_\_\_ Gender(Include any indo with Gender on Health form): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade Just Finished \_\_\_\_\_ Year of HS Graduation \_\_\_\_\_ T shirt Size(YS, YM, YL,S,M,L,XL, 2X) \_\_\_\_\_

List any person who cannot pick up your child and the reason:

\_\_\_\_\_

Does Camper Swim \_\_\_\_\_ Elementary, Junior Camper cabin-mate request (1 name only/must be mutual): \_\_\_\_\_

Participant Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Telephone: ( \_\_\_ ) \_\_\_\_\_ Participant Cell Phone: ( \_\_\_ ) \_\_\_\_\_

Local Congregation & City \_\_\_\_\_ Pastor's or Youth Pastor's Name \_\_\_\_\_

Pastor or Youth Pastor's Email Address: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Complete Address (if different from Participant): \_\_\_\_\_

\_\_\_\_\_ Cell Phone: ( \_\_\_ ) \_\_\_\_\_ Other Phone: ( \_\_\_ ) \_\_\_\_\_

Secondary Parent/Guardian's Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Complete Address (if different from Participant): \_\_\_\_\_

\_\_\_\_\_ Cell Phone: ( \_\_\_ ) \_\_\_\_\_ Other Phone: ( \_\_\_ ) \_\_\_\_\_

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

Relationship to Participant: \_\_\_\_\_ Primary Phone: ( \_\_\_ ) \_\_\_\_\_ Other Phone: ( \_\_\_ ) \_\_\_\_\_

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) and Missouri Union Presbytery 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) and Missouri Union Presbytery newsletters, promotion or other print, digital or internet publications. \_\_\_\_\_ Signature of Custodial Parent/Guardian (or Adult Camper/Staff) \_\_\_\_\_

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

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Health History for (Participant name) \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_ Date of Last Tetanus \_\_\_\_\_

Insurance Information: Is the participant covered by medical /hospital insurance (Yes or No) \_\_\_\_\_ If so, list Name On Card: \_\_\_\_\_

Carrier or plan name: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Dentist/Orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

<b>Medication &amp; Dosage.</b>	<b>When given &amp; reason for taking medication</b>
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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.

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

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**Mental, Emotional and Social Health: Please write yes or no and use the space below to further explain in needed**

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 and payment to your local church if Disciples.**  
**All others, return items to CCMA Registrar c/o First Christian Church 307 West Jackson Street Mexico, Mo 65265**