NEOLA/MUP Try It Camp

Return completed, signed form with the following items to your local church if Disciples or Missouri Union Presbytery .
All others, send items to
CCMA Registrar PO Box 774 Mexico, Mo 65265

1) Copy of front and back of insurance card 2) Payment of fee - make check out to your local church

Please complete one form for each family unit

First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus
First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus
First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus
First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus
First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus
First and Last Name	☐ Adult (over 18)	☐ Child	Child's Age	☐ Male ☐ Female	Last Tetanus

Address	**Phone**
City	**State** **Zip**
Email Address	**Best Method of Contact:** ☐ **Email** ☐ **Phone** ☐ **US Mail**

Special Requests (For example, "We want to share a cabin with [name] family.")	*We will do our best to honor special requests. They will be fulfilled in the order received.*

Camp T-shirts (1/person. Put Number need in each box)	Youth S	Youth M	Adult S	Adult M	Adult L	Adult XL	Adult XXL	Adult XXXL

Housing Options for Try-It Camp

Prices are for 1 adult /1 child combination in cabin, with an option for either one extra single adult or extra child. ***Questions?? Email zanew78@gmail.com or call 1-660-998-4158.***

Housing:	☐ **Adult + child pair $235**	☐ **Add'l Adult $65**	☐ **Add'l Child $65**		**Total**	**$**

*** Fee includes housing, meals and all program expenses for Friday dinner—Sunday breakfast.**

Releases and Authorizations: *please sign and initial as directed*

This Registration & Health History is correct and complete as far as I know. The person herein named as "camper" 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 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 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 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 camp representatives of the protected health information of the person herein described, as necessary; (1) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (2) in the case of minors, relevant information to the camp 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 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.

Please initial Transportation, Photography, and Medication Releases:

1.____ 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 the Northeast and Ozark Lakes Areas of the Christian Church (DOC) and Missouri Union Prebetery (MUP).

2.____ 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 Northeast and Ozark Lakes Areas newsletters, promotion or other print, digital or internet publications.

3.____ I authorize camp staff to administer over-the-counter medication to my child for minor pain, headache, upset stomach, sore throat, cold symptoms, or allergy.

_____

Signature of Custodial Parent/Guardian (or Adult Camper/Staff) **Date**

_____ **Printed Name**

Participant's Covenant

As a family, we covenant with our Creator, the camp staff, and other campers to do our best while at camp to:

- Expect the best of others, and give our 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 camp session.
- Be a good steward of creation, appreciating and caring for the environment at camp.
- Abide by the camp rules, policies, and expectations.
- Grow in our 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 camp property and the property of other campers and staff.

_____

Family Representative's Signature **Date**

Health History (complete one for each individual)

Camper Name: _____ **Date of Last Physical Exam** _____

Insurance Information: Is the participant covered by medical /hospital insurance ☐ Yes ☐ No

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 camper eats a regular diet. ☐ This camper eats regular vegetarian diet. ☐ This camper has special food needs.

Please describe any special dietary needs below. If additional space is needed, please attach an additional sheet.

MEDICATIONS BEING TAKEN ATCAMP (including vitamins and over-the-counter or non-prescription drugs)

If you are staying in lodging with just your family, you may keep and administer medications yourself. If you are sharing lodging with adults or children other than your own family, medication must be checked in to the camp medic/nurse and will be administered by camp medical staff. 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.

GENERAL HEALTH: Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet or write on back of this form if more space is needed. For travel outside country, please name countries visited.

Has or does the camper:	YES	NO	**Has or does the camper:**	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. Had headaches?	☐	☐	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 or write on back of this form if more space is needed.

Has the camper:	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 affects the camper? (abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)	☐	☐
5. Had a loved one serving in the military (currently or in the recent past)?	☐	☐

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