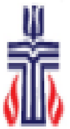

**2024 Mid-America Disciples & Missouri Union Presbytery Summer Ministries Registration and Health History**

***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): CYF (9th 12th Grade July 8-13 $230) ___
Elem/Junior (2nd-5th Grades July 15-19 **Elem Camp Leaves late afternoon of 17th** Elem $150 Jr***)___ Chi-Rho(6th-7th Grades July 28-Aug 2 $230)___

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, etc)_________

List any person who is not to pick up your child and list 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: (___)**______________________

| **ALLERGIES List all known**<br>Include medicines, food, insect stings or bites, hay fever, asthma, animal, etc. | **Describe reaction and management of reaction**<br>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 |
|---|---|---|
| 1. Had a recent injury, illness or infectious disease? | ☐ | ☐ |
| 2. Have a chronic or recurring illness/condition? | ☐ | ☐ |
| 3. Ever been hospitalized? | ☐ | ☐ |
| 4. Ever had surgery? | ☐ | ☐ |
| 5. Ever had a head injury? | ☐ | ☐ |
| . Had fainting or dizziness? | ☐ | ☐ |
| 8. Ever had seizures or convulsions? | ☐ | ☐ |
| 9. Ever passed out/had chest pain during or after exercise? | ☐ | ☐ |
| 10. Have diabetes? | ☐ | ☐ |
| 11. Have asthma/wheezing/shortness of breath? | ☐ | ☐ |
| 12. Ever had back/joint problems? | ☐ | ☐ |
| 13. Have any skin problems (e.g. itching, rash, acne)? | ☐ | ☐ |
| 14. Had mononucleosis (“mono”) in the past 12 months? | ☐ | ☐ |
| 15. Had problems with diarrhea/constipation? | ☐ | ☐ |
| 16. Have problems with falling asleep/sleepwalking? | ☐ | ☐ |
| 17. If female, have problems with periods/menstruation? | ☐ | ☐ |
| 18. Have a history of bedwetting? | ☐ | ☐ |
| 19. Wear glasses, contacts, or protective eyewear? | ☐ | ☐ |
| 20. Traveled outside the country in the past 9 months? | ☐ | ☐ |

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Mental. Emotonal and Social Health: Please write yes or no and use the space below to further explain in needed

**1. Ever been treated for attentiondeficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ____**
**2. Ever been treated for emotional orbehavioral difficulties or an eating disorder?____**
**3. During the past 12 months, seen a professional to address mental/emotional healthconcerns?___**
**4. Had a significant life event that continuesto affect the camper’s life?**
**(history of abuse, death of a loved one, family change adoption, foster care, new sibling,survived adisaster, other…) ____**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**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 PO Box 774 Mexico, Mo 65265***