

Camp use only: Registration paid _____

**CAMP STOVER CHURCH OF THE BRETHREN
CHILD REGISTRATION & CONSENT FORM**

Use separate form for each camper - Please print

Name of Camper _____

Address _____
Street City State Zip Code

Home Phone () _____ Child's Cell# _____ Birth Date _____

Age on September 1st. 2017 _____ Male ___ Female ___ Local Brethren Church _____

Camper's e-mail _____ Parent e-mail _____

Please list any dietary needs: _____

T-Shirt Sizes:

Child	<input type="checkbox"/> Small	<input type="checkbox"/> Medium	<input type="checkbox"/> Large	<input type="checkbox"/> XL		
Adult	<input type="checkbox"/> Small	<input type="checkbox"/> Medium	<input type="checkbox"/> Large	<input type="checkbox"/> XL	<input type="checkbox"/> XXL	<input type="checkbox"/> XXXL

Activity Permission and Authorization for Consent to Treatment of Minors: To the best of my knowledge, the information provided on this form and following pages is accurate and complete. My child, named above, has my permission to attend Camp Stover/Church of the Brethren, and to go on hikes and trips away from Camp, and I have made note of any special circumstances and/or restrictions in the space provided. ___ Yes ___ No **** Parent/guardian initials _____**

My child may be released to the emergency contact person in the event that I cannot be reached. ___ Yes ___ No ****Parent/guardian initials _____**

Camp Stover may use my child's pictures for promotional use if they appear in Camp pictures taken this year. ___ Yes ___ No ****Parent/guardian initials _____**

While attending or traveling to and from Camp Stover or special activities, I hereby authorize the adult accompanying or assisting my child to consent to any X-Ray examination, any anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and/or surgeon, or to any X-Ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provision of the dental practice act.

**** After marking and initialing the above 3 items, please sign one of the following:**

- This authorization is given for the protection and preservation of my child and Camp Stover/Church of the Brethren, under and pursuant to the laws of the State of Idaho governing such cases.

Date _____ Signature _____

- I do not desire to sign this authorization and understand this information will be in the leader's possession.

Date _____ Signature _____

NOTE: "Age Group" Campers must check out with their counselor(s) before leaving Camp.

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**CAMP STOVER CHURCH OF THE BRETHREN
INFORMATION AND MEDICAL HISTORY FORM**

(Required for each child who have/will turn 9 years old by Sept. 1st 2017 - 12th grade/staying in age group cabins)

Child's Name _____
Last First Middle

Father's Name _____

Address _____

Employer _____

Home Phone _____ Work Phone _____

Mother's Name _____

Address _____

Employer _____

Home Phone _____ Work Phone _____

Emergency Contacts (in event that a parent cannot be reached):

1. _____
Name Address Phone

2. _____
Name Address Phone

Name of Family Physician _____ Phone _____

Family Medical/Hospital Insurance Carrier _____

Group or Policy Number _____

Philippians 4:5 "Let your moderation be known to all men..."

Camp Stover is thankful for the cooperation of parents and campers who work together to maintain dress standards. Swimsuits are to be worn only when at the pond, or when going to or from Zims. String bikinis are not allowed. Not permitted are: revealing or risqué outfits or clothing that has holes purely for fashion or shirts worn to show off your stomach. Such dress will not be allowed. We are an inter-generational camp...if it might make someone uncomfortable to see it, then you will be asked to change.

All campers at Camp Stover are expected to conduct themselves in a Christ-like manner. The leadership of Camp Stover recognizes that campers are learning and growing to be responsible. The Camp reserves the right to dismiss any camper that is disruptive, disrespectful or cannot follow camp rules. Parents/Guardians will be notified and the child will be sent home.

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Health History Record

Part I: Illness and injuries (check all that apply)

_____ Ear Infection _____ Bleeding/Clotting Disorders _____ Hypertension

_____ Asthma _____ Heart Defect/Disease _____ Seizures

_____ Diabetes _____ Musculoskeletal Disorders

_____ Other (please specify) _____

Is there a course of action you pursue at home for any of the above conditions marked that you want us to continue at camp? Yes ___ No ___ If so please explain. Use an additional paper as needed.

Part II: Allergies (check all that apply and specify nature of allergic reaction)

Allergy _____ **Course of action you want us to pursue if any** _____

_____ Animals _____

_____ Hay Fever _____

_____ Pollen _____

_____ Food _____

_____ Medicines/Drugs _____

_____ Insect Stings _____

_____ Plants _____

_____ Other _____

Part III: Other Health Conditions (check all that apply)

_____ Bed Wetting _____ Sleep Disturbances _____ Motion Sickness

_____ Constipation _____ Emotional Disturbances _____ Menstrual Cramps

_____ Nose Bleeds _____ Hearing Impairment _____ Fainting

_____ Behavior disorder _____ Special Learning Needs _____

_____ Other (specify) _____

Please explain any items that are checked. Indicate any information that the adult in charge of your child may need to know concerning any of these health conditions and what if anything you do to treat this condition at home. Also, indicate any activity to be encouraged or restricted.

Part IV: Immunizations

Are your child's immunizations current? _____ Yes _____ No Tetanus Shot date _____

If no, please indicate which ones are not current _____

NOTE: "Age Group" Campers must check out with their counselor(s) before leaving Camp.

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Note: Juniors will have their medication kept & administered by an adult.

Please list all medication your child is currently taking, (even if self administer by Jr. High or Youth camper) the prescribed dosage and normal time it is taken each day.

All prescription medication must be in a bottle labeled by your pharmacy.

(Add an additional sheet if needed or use the back of this form)

<u>Medication</u>	<u>Dosage</u>	<u>Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Jr. High and Youth Campers only, please initial one of the following:

_____ My child can administer their own medication. (Note: Still must be listed above.)

_____ An adult should have and administer my child's medication.



Please initial any of the following over the counter medications you would want our medical coordinator to provide to your child for aches, pains, bug bites, etc.

_____ Advil or Motrin (ibuprofen) – for aches, pains, and minor sprains

_____ Tylenol – for headaches or minor pains

_____ Pepto-Bismol – for upset stomach

_____ Benadryl (antihistamine) – for insect bites

_____ Calamine Lotion, Benadryl Cream, etc. – for itching

_____ Cough Drops – for cough or dry throat

_____ Sucrets – for sore throat

_____ Visine – for minor eye irritation

_____ Imodium A-D - for diarrhea

Note: Generics of the above over the counter medications may be used to keep costs down.

Additional concerns or instructions: _____

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Health History Record

Note: Your "Health History Record" will be kept confidential.

Part I: Illness and injuries (check all that apply)

_____ Ear Infection	_____ Bleeding/Clotting Disorders	_____ Hypertension
_____ Asthma	_____ Heart Defect/Disease	_____ Seizures
_____ Diabetes	_____ Musculoskeletal Disorders	_____ Cancer
_____ Other (please specify) _____		

Part II: Allergies (check all that apply and specify nature of allergic reaction)

_____ Animals	_____
_____ Hay Fever	_____
_____ Pollen	_____
_____ Food	_____
_____ Medicines/Drugs	_____
_____ Insect Stings	_____
_____ Plants	_____
_____ Other	_____

Please explain any items that are checked. Indicate any information that emergency personal should know concerning any of these health conditions. _____

Please list all past surgeries: _____

Please list all medication you are currently taking (including herbs) & the prescribed dosage and normal time it is taken each day or indicate where a list can be found in case of emergency (purse, wallet, spouse, etc.)

<u>Medication</u> (Add an additional sheet if needed)	<u>Dosage</u>	<u>Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____