

Partnering Organization _____ City/State _____

Director's Name _____ Email _____ Phone # _____

Adventure Week @ Camp Rockmont

201__

Camper Registration Form

(complete this form and return to your Partnering Organization to be eligible)

Campers Name _____ / _____ / _____
(last) (first) (middle)

Campers SS# _____ - _____ - _____ Date of Birth ____/____/____ Age _____

Parent/Guardian's Name _____ / _____ / _____
(last) (first) (middle)

Campers Address _____

City _____ State _____ Zip _____

Parent/Guardian's home phone # _____ Cell phone # _____

Emergency Contact Name _____ Phone # _____

What would you like your son's counselor to know about him? _____

Racial/Ethnic Identity

You are not required to answer these questions. If you choose to do so, please mark one of the following racial or ethnic identities:

- American Indian or Alaska Native
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Asian
- White

Does the camper know how to swim? Yes _____ (describe ability below) No _____

Parent/Guardian Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the Director of Camp Rockmont or his designee to provide routine health care; to administer medications; order x-rays, routine tests & treatment; to release any records necessary for insurance purposes; or to provide or to arrange necessary related transportation for my child. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for my child. I give permission for photographs and/or audio/video recording of my child to be used by the camp for its promotion, website and/or news media coverage. I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs offered during *Adventure Week* including but not limited to swimming, canoeing, climbing, target sports, and adventure elements, which could result in accidental injury, possibly serious. Parents will be notified immediately if a serious incident occurs. Furthermore, participation in these activities requires good physical condition by the participant. Being aware of the inherent risks and potential injury to my child, I hereby consent to my child's attendance and participation in the activities offered during *Adventure Week*.

Signature of Parent/Guardian _____ Date: ____/____/____

Medical Information (Must be filled out completely to be eligible for camp.)

Does the camper take any medications? Yes (please describe below) No

Please list any medications (including over the counter or non-prescription drugs) taken regularly. Bring enough medications to last the entire time at camp. Keep medications in their original bottle/package that identifies the prescribing physician (if prescription), the name of the medication, the dosage, and frequency of administration.

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Does the camper have any allergies? Yes (describe below) No

General Health Questions (Please explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had joint problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Plan to bring an orthodontic appliance to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? ..	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>	25. Have a history of bed-wetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had sought professional help with emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?..	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

If you marked yes to any of the above, please explain: _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Which of the following immunizations has the participant had?

- DTP
- MMR
- Rubella
- Haemophilus influenza B
- Polio
- Measles
- Hepatitis B
- TD (tetanus/diphtheria)
- Mumps
- Varicella (chicken pox)

Date of last Tetanus shot _____

Health Care Information

Name of regular physician _____ Phone (____) _____ - _____

Is the participant covered by an insurance plan? Yes (please describe below) No

Plan Name: _____ Group Number: _____

Insurance Company address: _____

Name of insured/policy holder: _____ Relation to participant: _____

Policy ID number of Social Security number of policy holder: _____

Use this space to provide any additional information about the participant of which the camp should be aware: _____

* Please provide a copy of health insurance and prescription drug card.