

Partnering Organization _____ City/State _____

Director's Name _____ Email _____ Phone # _____

Adventure Week @ Camp Rockmont

201____

Chaperone Registration Form

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

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

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

Chaperone's Address _____

City _____ State _____ Zip _____

Chaperone's Home Phone # _____ Cell Phone # _____

Emergency Contact Name _____ Phone # _____

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:

- | | | |
|---|---|--|
| <input type="radio"/> American Indian or Alaska Native | <input type="radio"/> Black or African American | <input type="radio"/> Hispanic or Latino |
| <input type="radio"/> Native Hawaiian or Other Pacific Islander | <input type="radio"/> Asian | <input type="radio"/> White |

Do you know how to swim? Yes _____ (describe ability below) No _____

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 myself. I give permission for photographs and/or audio/video recording of myself 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. Your Emergency Contact will be notified immediately if a serious incident occurs. Furthermore, participation in these activities requires good physical condition by the participant and so I am aware of the inherent risks and potential for injury to myself.

Signature _____ Date: ____ / ____ / ____

We are excited to have you join in this important camp experience. We appreciate your commitment to the boys in our care for the week. The questions below will help us determine how and where to best use your skills and talents. There will be a brief orientation upon your arrival to help integrate you into the camp community and program.

How long have you worked with this sponsoring organization? Please describe your work: _____

Have you worked with other youth organizations? If yes, please list their names and a brief description of your work with them: _____

What is your occupation? If a student, where are you in school and what are you studying? _____

Please describe below your talents and skills and what you hope to achieve during your time at camp: _____

Rockmont is a tobacco-free and drug-free environment, and the use of tobacco products or illegal drugs is prohibited on camp property or any camp-sponsored trip. Chaperones agree to abstain from tobacco entirely during their time at camp whether on or off camp. Are you willing and able to abide by this policy? Yes No

Rockmont is an alcohol-free environment, and the use of alcohol products is prohibited on camp property or any camp-sponsored trip. Chaperones agree to abstain from alcohol entirely during their term of employment, whether on or off camp. Are you willing and able to abide by this policy? Yes No

Do you have an visible tattoos or body piercings? Yes No

Have you ever been charged or convicted of a felony or misdemeanor? Yes No

Have you ever been charged with DUI (Driving Under the Influence of alcohol) or DWI (Driving While Impaired)? Yes No

I understand that a background check may be conducted. Yes No

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

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

Does the chaperone 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 _____

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

HAS/DOES THE PARTICIPANT:

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