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)

PLEASE PRINT

Camper's Name _____ / _____/ _____
(first) (middle) (last)

Camper's Nickname _____ Date of Birth _ _/_ _/_ _ Age_____ School Grade_____

Parent/Guardian's Name_____/ _____
(first) (last)

Camper's 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? _____

_____

_____

_____

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 have any allergies? ❑ Yes (please describe below) ❑ No

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 _____

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

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

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
- ❑ Polio
- ❑ Measles
- ❑ Hepatitis B
- ❑ Haemophilus influenza B
- ❑ TD (tetanus/diptheria)
- ❑ 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.***