

CAMP MOUNT LUTHER REGISTRATION AND HEALTH FORM 2012

CAMPER INFORMATION

Last Name:	First:	Middle:	Grade Completed in June 2012:	E-Mail:
Street Address:	City/State/Zip:		Birth Date: / /	Age: /
Parents' Name:		Home Phone: ()	Cell or Work Phone: ()	
Congregation:	City/State:		Cabinmate Request:	

INSURANCE INFORMATION

Does insurance require MD approval prior to care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, indicate the phone number to call: ()
Medical Insurance Carrier/Plan Name and Group Number:	Insurance ID Number:
Guardian Name on Policy:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home Phone: ()	Cell or Work Phone: ()
(For Day Camp) Person Responsible for Picking Up Child at the End of the Day:			Their Phone Number: ()

RESIDENT CAMP PAYMENT INFORMATION

<input type="checkbox"/> Check Enclosed for Amount: _____ <input type="checkbox"/> Bill Credit Card for Amount: _____ Visa / MasterCard / Discover / AMEX Card Number: _____ Expiration Date: _____ <input type="checkbox"/> Church Pays this Amount: _____ <input type="checkbox"/> Bill Diocese this Amount: _____ Are you a returning camper? No Yes (Please circle) <p>CAMP FEES: Non-refundable registration deposit is \$100. Camper portion of fees must be paid before registration day. To qualify for early registration incentive, you must pay the entire <u>camper</u> portion of fee. Fees are listed in each program's description.</p> <p><i>Please write your desired program below. You are assigned to a group based on the grade you complete in June. Please check age group requirements in the descriptions. If your first choice is filled, we will contact you with alternatives.</i></p> <p>PROGRAM INFORMATION:</p> WEEK # _____ DATES: _____ AGE GROUP: _____ PROGRAM: _____	<p style="text-align: center;">FIGURE OUT YOUR CAMP COST:</p> <p>BASIC PROGRAM FEE: _____</p> <p>LATE FEE (\$30 after 4/1; \$60 after 6/15): + _____</p> <p>SUBTOTAL: _____</p> <p>DISCOUNTS (see below): - _____</p> <p>GRAND TOTAL: _____</p> <p style="text-align: center;"><u>CHECK DISCOUNTS CLAIMING</u> <i>Maximum discount allowed is \$25; if discounts claiming equals more, you can take maximum amount.</i></p> <p>_____ \$15- Camperson Discount (if your congregation was represented at January Camperson Meeting)</p> <p>_____ \$10- Camperson Discount (if your congregation has a camperson but was not represented at January Camperson Meeting)</p> <p>_____ \$20- Bring a Friend (bring a friend or sibling who has never been to CML and both campers get \$20 off registration. Send both registrations together to qualify)</p>
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CAMP MOUNT LUTHER

FORM CONTINUES ON BACK- DOCTOR'S SIGNATURE REQUIRED!!!!

HEALTH INFORMATION is gathered to assist in identifying appropriate care. All but "Health Care Exam by Licensed Medical Personnel" is to be completed by a minor's guardian. All campers and staff must be examined by a licensed physician within the last 12 months. If bringing medications to camp, please leave them in their original containers. If you are unable to have the physician fill out the health portion before the registration deadline, send a photocopy of the incomplete form as your registration and mail in the health form when it is complete. **Please make a copy of the registration and health form and keep for your records in case it gets lost in the mail.**

Immunizations

Indicate below that the following are up to date:

DATE VACCINE

_____ DTP

_____ Tetanus/Diphtheria (TD)

_____ Tetanus

_____ Polio

_____ Measles (Hard, red, rubella)

_____ Rubella

_____ Hemophilus influenza B

_____ Hepatitis B

_____ TB Mantoux Test (Result: _____)

Health Information

Indicate below all known allergies (e.g. medication, food, insects, plants), past medical treatment, illnesses or important health history information we may need to know as well as any other information we should be aware of, including dietary concerns:

CONSENT & RELEASE PERMISSION: *For the purpose of this form if used for off-site day camps, "camp" refers to personnel of the off-site congregation and/or the Camp Mount Luther staff.*

I hereby give consent for camp personnel to give over-the-counter medications should it be necessary. I understand that the Camp Mount Luther Corporation and its employees are not responsible for untoward effects of nonprescription medications. (2) I give the camp permission to dispense my child's prescription medication as listed. (3) I hereby give permission to the medical personnel selected by the camp administration to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatments, including hospitalization, for the above named person. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. This completed form may be photocopied for trips out of camp. (4) I am interested in the policies, goals and programs of Camp Mount Luther and hereby give permission to my child to participate in the programs and activities of the camp he or she may attend. In the event hikes, field trips or camping trips are planned away from the camp as part of the camp program under the direction of the camp administration, my camper has my permission to participate in such activities. Any photos or video recordings taken in which my child appears may be used for promotion of camp and its related entities free of any claims. I have read the refund policy and agree to the provisions contained in it.

Signature (of parent if under 18) _____ Date _____

HEALTH EXAM CERTIFICATION BY LICENSED MEDICAL PERSONNEL FOR SUMMER CAMP

I have examined the named participant and in my opinion, he/she is able to participate in an active camp program with the following restrictions/recommendations or treatments at camp:

General Health of Camper: _____ Normal _____ Below Average _____ Sickly

The applicant is under the care of a physician for the following conditions:

The following medications are to be administered at camp:

Drug: _____ **Dosage:** _____ **Times Given (indicate breakfast, lunch, supper, bedtime)** _____

Has or will this individual be taken off any medications for the summer? _____ If yes, please explain why:

Date of last exam _____ BP _____ Weight _____ Height _____

Signature of Licensed Medical Personnel: _____ Date _____

Name of Family Physician: _____ Phone () _____

Name of Family Dentist: _____ Phone () _____

**HEALTH
SCREENING**
(to be
completed at
camp by health
officer)

Reviewed by

Date
