

## 2008 CAMP JOY HCJFS REGISTRATION FORM

We welcome participation of youth without regard to race, color, religion, sex, national origin, disability, ancestry, age, income eligibility, sexual orientation, or marital or family status.

**PLEASE PRINT CLEARLY**

Camper's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Circle One: M F Referred to camp by: \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_ County \_\_\_\_\_

School attended 2007/2008 \_\_\_\_\_ School District \_\_\_\_\_ Grade next fall \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Shirt Size: (Circle One) YS YM YL S M L XL XXL Ethnicity (Optional): Circle One: White African-Amer. Hispanic Asian Other

### CHOOSE PROGRAM DATES (CHECK)

\_\_\_\_\_ **Session 2: June 16-20** Children Services: ages 7-15. Most campers are affiliated with the foster care system.

\_\_\_\_\_ **Session 5: July 7-11** Core Camp: ages 12-16. A kick-off camp for the year round leadership program.

\_\_\_\_\_ **Session 6: July 16-25**, Leadership-In-Training Camp Rustic leadership program for ages 15-16.

\_\_\_\_\_ **Session 7: July 28-August 1** Camp Reunite: ages 7-16. A program to reunite biological siblings who are separated in different foster homes.

#### PARENT/GUARDIAN/FOSTER PARENT INFORMATION

1. Parent/Guardian's/Foster Parent's name \_\_\_\_\_ Relationship \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

2. Parent/Guardian's/Foster Parent's name \_\_\_\_\_ Relationship \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

Home Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Additional Phone #s/Pagers, etc \_\_\_\_\_

#### AGENCY INFORMATION

List any affiliated agency or service working with this child \_\_\_\_\_ Contact/Social Worker \_\_\_\_\_

Phone #'s/Pagers 1.) \_\_\_\_\_ 2.) \_\_\_\_\_ Is this camper a ward of the state? (Optional) \_\_Yes \_\_No

#### IF PARENT/GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ 2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION FOR CAMPER PICK-UP** Any additional persons to whom child may or may not be released:

May \_\_\_\_\_  May not \_\_\_\_\_

#### TRANSPORTATION \*\*\* NEW LOCATION

(CHECK TWO) Bus service is available from **Carl H. Lindner YMCA is located** at 1425B Linn Street, Cincinnati, OH. 45214

**BUS PICK-UP IS MONDAY AT 9:30 AM.**

- Monday** bus transportation
- Will Drop My child of at Joy on Monday at **11:00am**

**BUS DROP-OFF IS FRIDAY AT 2 PM.**

- Friday** Bus Transportation
- Will Pick up my child at Joy on Friday at **12:30pm**

#### **Acknowledgement of Risk and Release- Joy Outdoor Education Center, LLC (JOEC).**

- I understand that participation in programs offered by JOEC is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that participation is purely voluntary, and elect to allow my child's participation in spite of the risks.
- I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, canoeing, biking, swimming, archery, field games, off site adventure trips, and other activities at JOEC, for which I and / or my child have enrolled, entail certain risks.
- I understand that completing and signing JOEC's Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.
- Therefore, for myself / my child, I expressly, knowingly and voluntarily assume all risks involved in my / my child's participation, and do hereby release JOEC and its members, trustees, officers, employees, independent contractors and agents from any and all liability, damages, costs and expenses arising out of or relating to bodily or psychological injury, loss of life or personal property that may occur as a result of participating in this program.
- I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the program.

**Signature of parent/legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

#### **PERMISSION FOR PUBLICITY (OPTIONAL)**

I, the undersigned, give my consent for my child to be photographed for general camp and/or agency printed / internet publicity.

**Signature of parent/legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Health Exam – to be filled out by a Licensed Physician, Physician’s Assistant, or Nurse Practitioner**

.....

Camper Name \_\_\_\_\_

Health Professional’s Name \_\_\_\_\_ Health Professional’s Signature \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

Date of last exam (Must be after Aug, 2006) \_\_\_\_\_

List current or on-going medications and treatment:

\_\_\_\_\_  
\_\_\_\_\_

List any physical conditions requiring restrictions on the camper’s participation at camp:

\_\_\_\_\_  
\_\_\_\_\_

List anything Joy staff should know about this camper to best serve the child and keep them safe.

\_\_\_\_\_  
\_\_\_\_\_

# 2008 CAMP JOY HEALTH FORM

Camp Joy, PO Box 157, Clarksville, OH 45113 1-800-300-7094

THIS SECTION TO BE COMPLETED WHEN CAMPER IS DROPPED OFF FOR CAMP:

Has any information changed since this was originally filled out? Yes / No

Guardian's Initials \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

APPLICATION WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

This form should be completed by the camper's parent or guardian.

Camper's Name \_\_\_\_\_

## PHYSICIAN & INSURANCE INFORMATION

Family Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Family Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical/Hospital Plan: \_\_\_\_\_ Policyholders First & Last Name \_\_\_\_\_

Health Insurance Company/Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

## MEDICAL CONDITIONS:

- Ear Infections
- Asthma
- Do you carry an inhaler? \_\_\_\_
- Diabetes
- Headaches
- Infectious Hepatitis
- High Blood Pressure
- Psychiatric Care
- Pregnancy
- Heart Disease
- Fainting
- Convulsions/Seizures/Epilepsy

Date of last seizure \_\_\_\_\_

Please describe management of the above conditions / allergies: \_\_\_\_\_

Describe and give dates of any hospitalizations, serious injuries or recurring illnesses: \_\_\_\_\_

List any diet / Camp activity restrictions: \_\_\_\_\_

List any current physical, mental or psychological conditions requiring medication, treatment or, restrictions at camp: \_\_\_\_\_

## ALLERGIES:

- Hay Fever
- Ivy Poisoning, etc.
- Penicillin
- Other drugs (please specify): \_\_\_\_\_
- Peanuts: Explain severity: \_\_\_\_\_

## Insect Stings

What type of reaction do you have to stings? \_\_\_\_\_

Do you use an epi-pen for stings? \_\_\_\_\_

List any other allergies (food, plants, etc.): \_\_\_\_\_

## MEDICATIONS

Prescribed and Over the Counter Medicine to take at Camp Name/Reason

1. \_\_\_\_\_ / \_\_\_\_\_
2. \_\_\_\_\_ / \_\_\_\_\_
3. \_\_\_\_\_ / \_\_\_\_\_

## IMMUNIZATIONS AND HISTORY:

(Give year of last immunization)

- \_\_\_\_ DPT Series
- \_\_\_\_ Tetanus Booster
- \_\_\_\_ Polio
- \_\_\_\_ Mumps
- \_\_\_\_ Measles
- \_\_\_\_ Tuberculin Test
- \_\_\_\_ German Measles (Rubella)
- \_\_\_\_ Hepatitis B Series
- \_\_\_\_ Chicken Pox

## Have you had or been exposed to:

- | Have you had or been exposed to:         | Date: |
|------------------------------------------|-------|
| <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Chicken Pox     | _____ |
| <input type="checkbox"/> Measles         | _____ |
| <input type="checkbox"/> German Measles  | _____ |
| <input type="checkbox"/> Mumps           | _____ |
| <input type="checkbox"/> Other           | _____ |

## In case of pain, give this participant:

Acetaminophen (Tylenol) \_\_\_\_\_ Ibuprofen (Advil) \_\_\_\_\_

Nothing \_\_\_\_\_ Other (List) \_\_\_\_\_

## PARENTAL ACKNOWLEDGMENT AND CONSENT

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by Joy Outdoor Education Center, LLC (JOEC) to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes; I give permission to JOEC to 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 JOEC to secure and administer treatment, including hospitalization, for the person named above. I give permission to the JOEC medical staff to assist my child with over-the-counter medication if needed.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Completed upon arrival by Staff:

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_ Cabin # \_\_\_\_\_ Session # \_\_\_\_\_

- \_\_\_\_\_ Looks and feels well
- \_\_\_\_\_ Any skin conditions
- \_\_\_\_\_ Recent injuries
- \_\_\_\_\_ Head lice or scalp problem
- \_\_\_\_\_ Physical challenges/disabilities?
- Describe above ? \_\_\_\_\_

Additional information for the health care provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_