

2010 Kids' Breakaway: Camper Application

Camper's Name: _____ Age: ____ Gender: M F Grade completing: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name(s): _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email: _____

Church Name: _____ City: _____

Please mark appropriate weekend:

- Weekend #1: February 26-28
- Weekend #2: March 5-7
- Weekend #3: March 12-14

Today's Payment:

- \$30 Breakaway Deposit
- \$95 Breakaway Full Payment (postmarked by 2/10)
- \$20 Breakaway Late Registration Fee (postmarked after 2/10)
- \$10 T-shirt (please circle size below)
(S M L XL XXL XXXL - Adult Sizes)

Please turn in the completed camper application with deposit to your church group leader. Incomplete applications will be charged \$10.

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate the carrier or plan name: _____ Group # _____

Family Physician/Pediatrician Name: _____ Phone # _____

PARENTAL CONSENT AND MEDICAL AUTHORIZATION

This camper application and health history is correct and complete as far as I know. The person herein named has permission to engage in all breakaway activities except as noted. I hereby give permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications and emergency treatment for my child, as may be necessary, including but not limited to x-rays, routine tests and treatment and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to release any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting in *loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event that I cannot be reached in an emergency, I hereby give permission to the Nurse/Physician/Staff selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp. In addition, I also consent to photographs and/or video images of the above listed camper for use within the scope of PennDel Ministry Network advertisements and brochures.

Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

HEALTH HISTORY: Please complete health history on the reverse side. Incomplete applications will be charged \$10.

The following information must be filled in by the parent/guardian. The intent of this information is to provide the camp health care personnel with the background to administer appropriate care. Keep a copy of the completed form for your records. This information will be included on the Medical Update form and given to the camp staff at the time of registration. Provide complete information so that the camp can be aware of your child's needs.

Camper Name: _____

Date of last tetanus shot: _____ Unsure of exact date All immunizations are current

Medication Allergies

Describe reaction and management of the reaction.

Food Allergies - Please list any medical food allergies. If your child has medical dietary needs, please call (717) 243-7391 or e-mail ajurado@penndelcc.org and speak with Albert Jurado, Food Service Director. We are not a peanut free facility. While we do not intentionally use peanuts or peanut products, some foods may be processed in facilities that handle peanuts or peanut products.

Other Allergies - Include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN This person takes **NO medications** on a routine basis.

Our Medical Personnel can only dispense medications in the **original packaging/bottle** that identifies the **prescribing physician** (if a prescription drug), the **name of the medication**, and the **dosage and frequency of administration**. Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) that are taken routinely. Send enough medication to last the entire weekend of breakaway; no more, no less.

This person takes medications as follows:

Med #1: _____ Dosage: _____ Specific time taken each day: _____

Reason for taking: _____

Med #2: _____ Dosage: _____ Specific time taken each day: _____

Reason for taking: _____

Med #3: _____ Dosage: _____ Specific time taken each day: _____

Reason for taking: _____

Attach additional pages for more medications.

I give permission for the on-site medical personnel to administer the following medications to my child when necessary:

Tylenol (Acetaminophen) Advil (Ibuprofen) Benadryl (Diphenhydramine)

RESTRICTIONS: The following dietary restrictions apply to this individual.

Does not eat meat. Does not eat eggs. Does not eat dairy products. Other:

Explain any physical restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary):

Bed Wetting Yes No **Bed Wetting precautions taken:** _____