Sponsored by: **Life Community Church** 626 West Bottom Ave. Columbia, IL 62236 618-541-0377 Child Name: Age:	CAMP **one life** for children in foster care ages 6-12 years old **Camp Date: July 22-26, 2024**	**Return Completed Application to:** Life Community Church Attn: Kelly Meurer 626 West Bottom Ave. Columbia, IL 62236 ***Please enclose a photo of the camper.***

REGISTRATION FORM

_____

Child's Last Name First Name Preferred Name Sex Birthdate

_____Str

eet City Zip

_____

Age Current Emotional Age School Grade

The child is living with: (Circle one) Foster Parent Group Home Relative

_____

Name(s) of person(s) the child is living with

_(_____)_____//_(_____)_____

Home Phone: Work Phone

_____(_____)_____

Emergency Contact Phone

_____

Relationship to Child

_____(_____)_____

Social Worker Day Phone Number

Explain any unusual family circumstances that make camp especially important for the child: (for example: recent crisis, being moved in a foster placement, severe economic needs, etc.)

_____

_____

_____

CAMPERS EMOTIONAL/BEHAVIORAL HISTORY

	Often	Sometimes	Not at all
Aggressiveness	___	___	___
Bedwetting	___	___	___
Biting	___	___	___
Eating Disorders	___	___	___
Hyperactive	___	___	___
Learning & Disabilities	___	___	___
Lying	___	___	___
Night Terrors	___	___	___
Nightmares	___	___	___
Runs Away	___	___	___
Sexual Acting Out	___	___	___
Steals	___	___	___
Tantrums	___	___	___
Withdrawn	___	___	___

Details from above:

_____

With behaviors how do you respond? We want to try to stay consistent with what you're doing at home:

_____

_____

CAMPER DETAILS:

This child's swimming ability is: Good Poor Do not Know

Learning Disabilities: Yes // No

Has the child attended a sleep away CAMP before? Yes // No

Where?_____

Camper T-Shirt Size: Child Small // Child Medium // Child Large //

Adult Small // Adult Medium // Adult Large

HEALTH HISTORY

Indicate all known allergies, illness, disabilities, physical limitations or medical complications:
Allergies

_____Illn

esses/medical complications

_____

Disabilities/Limitations_____

Leg or Arm Braces Hearing Aids Eating Disorder Yes // No

Indicate date of illness, severity, complications, and any residual impairments.
Respiratory Problems _____ Hypoglycemia_____ Musculoskeletal ____
Allergies _____ Heart or Circulation_____ Dizzy Spells_____
Seizure Disorders_____ Poison Oak/Ivy_____ Diabetes_____ Fainting_____
Insect Bites_____ Drug Allergy_____ Other_____

Details from above:

_____

_____

Any specific activities to be encouraged?

_____

Any specific activities to be restricted?

_____

PRESCRIPTION MEDICATIONS: *All medication sent to camp must be in original container with the pharmacy label on it.*

Is your child taking any medications? No // Yes, please fill in the following

1. Name_____Dosage:_____Times:_____
2. Name_____Dosage:_____Times:_____
3. Name_____Dosage:_____Times:_____

What is(are) the medication(s) for:

_____

Doctor's Name

_____Phone_____

Please add any other comments related to HEALTH and MEDICATIONS on an additional sheet.

I understand that it is my responsibility as caregiver to make sure that all instructions are clear and that the necessary dosage is adequately supplied for the duration of CAMP. I hereby authorize **one life** CAMP nurses to administer the above medication from _____ to _____. Day/Date
Day/Date

_____ _____

Parent or Legal Guardian Signature Printed Name

MEDICAL RELEASE FORM:

This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of **one life** CAMP, or such substitute as they may designate, as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is enroute to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Director of **one life** CAMP as legal guardian/social worker/other. I give my permission for _____ to attend **one life** CAMP in the summer of _____ through **Life Community church**.
Camper
Year

_____ _____ _____

Authorized Signature Printed Name Date

Child's Medicaid # _____

Signature:_____

Relationship to child _____Date_____

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

I hereby give the **one life** CAMP Registered Nurse permission to administer the following products according to manufacturer's instructions, or as otherwise specified.

I trust the **one life** CAMP Registered Nurse to use her best judgment as situations arise, and if in doubt, he/she can call for verification.

Please check YES or NO for the medications listed blow. This form must be completely filled out by the primary caregiver who signs below, or camper may not attend camp.

Circle one:		Specify if desired:
yes/no	Sunblock	_____
yes/ no	Insect repellent	_____
yes/no	Lip balm	_____
yes/no	Rash ointment	_____
yes/no	Tylenol	_____
yes/no	Antiseptic ointment	_____
yes/no	Band-aids	_____
yes/no	Anti-itch cream	_____
yes/no	Hydrogen peroxide	_____
yes/no	Cough syrup	_____
yes/no	Cough drops	_____
yes/no	Decongestant	_____
yes/no	Antihistamine	_____
yes/no	Other	_____
yes/no	Other	_____

Parent or Legal Guardian's Signature: _____

Printed Name: _____ Phone numbers: _____

Person Authorized to pick-up child _____

PLEASE NO CAMERAS, PHONES OR MONEY.
THESE ITEMS ARE NOT NEEDED AT CAMP.