❖ Register my family for Event: _____

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ (Month/Day/Year) ☐ Male ☐ Female

❖ Main adult family member to send camp information: Name _____

Mailing Address _____

City, State, Zip _____

Home Phone (_____) _____ E-mail _____

❖ For planning purposes, are there any concerns or dietary needs that we should be aware of? ☐ Yes ☐ No

Please explain _____

$50.00 non-refundable deposit per family (not per family member) is required.

To Register By Mail: (Registrar, Illinois Conference Outdoor Ministries, 26449 1340 N Ave, Princeton IL 61356-8790)
Please make your check payable to ***Outdoor Ministries***

To Register By Phone: (815-447-2390) or **Fax:** (815-447-2205) or **E-mail:** odmregistrar@gmail.com

Pay by Check: Check Number _____ Amount $_____

Charge my (check one) ☐ Visa ☐ MasterCard Amount $_____

Card Number _____ Exp. Date _____ CVS# (3 digits on back)_____

Signature _____ Date _____

Name Printed on Card _____

Mailing Address _____ Zip _____

If your church is going to assist your camper financially, fill in the amount they will be contributing: $ _____
(Note: Family is responsible for full amount until church portion is paid.)

Church Name _____ City/Town _____

SIGNATURE REQUIRED

I confirm that the information provided is correct to the best of my knowledge. I understand that **a $50.00 non-refundable deposit is required per family** at registration in order to guarantee a spot at camp and the **remaining family balance is due no later than 2 weeks prior to the start of camp.** I understand that if I find it necessary to cancel a registration, cancellations must be made at least 2 weeks prior to the event in order for me to receive a refund and that the $50.00 deposit is non-refundable will be held as a service fee.

Signature _____ **Date**_____

ADULT PERMISSION & HEALTH STATEMENT

EVENT NAME: _____

This form must be completed & signed by ALL Adults (1 adult per form).

Yes No

☐ ☐ I give permission for audio and visual recordings of myself to be used by Outdoor Ministries and the Illinois Conference of the UCC for promotional purposes.

Please PRINT:

First Name: _____ Last Name: _____

Birthdate: _____/_____/_____

I have the following health issues: _____

_____

_____

I have the following dietary restrictions or food allergies: _____

_____

_____

Please compete:

Emergency Contact Person: _____

Day Phone Number: (_____) _____

Evening Phone Number: (_____) _____

X _____

Signature *Date*

Health History Record

This form must be completed & signed for *ALL* campers, CITs, counselors, directors and site staff.

The health history record is to be completed and signed for all campers participating in Resident Camp Programs. The information on this form is confidential, and will only be used to ensure the health and safety of all participants. Photocopies will be made for off-site trips. **PLEASE PRINT**

Name	Home Phone ( )	Date of Birth / /	Age	Gender
Mailing Address	City	State	ZIP	
Mother/Guardian/Spouse (**please indicate**)	Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Mailing Address	City	State	ZIP	
Father/Guardian/Spouse (**please indicate**)	Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Mailing Address	City	State	ZIP	
Additional Emergency Contact, Relationship	Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Physician Name	Town	Phone ( )		
Family Medical Insurance Carrier	Policy or Group Number	Name of Insured	Insured Date of Birth / /	

Health Conditions: **Check those that apply and provide additional information when necessary or mark:** ☐ **None**

☐ Asthma ☐ Bleeding/Clotting Disorders ☐ Heart Defect/Disease ☐ Seizures

☐ Fainting ☐ Depression ☐ Sickle Cell Trait or Disease ☐ ADD/ADHD

☐ Anxiety ☐ Musculoskeletal Disorders ☐ Diabetes (specify) _____

☐ Nosebleeds ☐ Hypertension ☐ Autism Spectrum (specify) _____

☐ Other (specify) _____

Allergies: **Check those that apply and provide additional information when necessary or mark:** ☐ **None**

☐ Animals ☐ Insect Stings (specify) _____

☐ Latex ☐ Food Allergy (specify) _____

☐ Plants/Pollen ☐ Drug Allergy (specify) _____

☐ Other Allergies (specify) _____

Other Information

❖ Camper wears the following:	☐ Hearing Aid	☐ Knee Brace	☐ Other Brace
❖ Camper has experienced puberty changes:	☐ Yes	☐ No	
❖ Camper needs assistance walking on uneven ground:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has sleep disturbances:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has nightmares:	☐ Yes	☐ No	☐ Sometimes
❖ Camper sleepwalks:	☐ Yes	☐ No	☐ Sometimes
❖ Camper wets the bed:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has fears that are outstanding:	☐ Yes	☐ No	

If so, what are they?: _____

Medication for Minors

Should a medical concern arise at Resident Camp, the camp may have the following non-prescription medications available. Please state whether or not the following may be administered to camper on an as needed basis:

(Note: We cannot administer any over-the-counter medication unless granted permission by guardian. Please check box "Yes" if you will allow camp staff to administer that medication. Use the space to the right for any specific directions or dosages you would like the camp to be aware of.)

Acetaminophen/Tylenol	☐ No	☐ Yes	_____
Ibuprofen/Advil/Motrin	☐ No	☐ Yes	_____
Naproxen Sodium/Aleve	☐ No	☐ Yes	_____
Diphenhydramine/Allergy/Benadryl	☐ No	☐ Yes	_____
Antacids/Tums	☐ No	☐ Yes	_____
Triple Antibiotic Ointment/Neosporin	☐ No	☐ Yes	_____
Topical Hydrocortisone	☐ No	☐ Yes	_____
Topical Antihistamine/Benadryl Cream	☐ No	☐ Yes	_____
Ear & Eye Drops	☐ No	☐ Yes	_____

Does camper regularly take medication (prescription or non)? ☐ No ☐ Yes

If yes, please list the medication, dosage, what it is for, and when it is taken. **Note: All medications whether prescribed or over-the-counter, must be in their original containers or packages.** _____

_____

_____

_____

Please specify any dietary needs (such as vegetarian, dietary restrictions, or food allergy) that may be affected at camp. Please contact the camp office before arrival if special food is needed. _____

_____

_____

_____

Is there any information you would like to add regarding the information on this form? Please include anything you may feel is relevant. (If needed, use a separate piece of paper and staple to this form.) _____

_____

_____

_____

Immunization Record

Please provide the month and year for each immunization. Starred (*) immunizations must be current.

Immunization	Polio	Mumps	Diphtheria	***Tetanus**	Pertussis	Measles	Rubella	Hepatitis	Other
Date initial immunization completed									
Date of most recent booster									

Medical Treatment *(Signature Required)*

I give permission for the camp and medical personnel selected by the camp to provide routine health care; to administer medications; to order X-rays, routine tests, emergency treatment; to release any records necessary for insurance purposes; and to provide transportation to the hospital for me/my child/ward. I also authorize emergency care and treatment to be provided for my child/ward in the event that I cannot be reached. I realize that every effort will be made to contact me before treatment begins.

X _____ _____

*Signature (parent/guardian if minor) Date

**If for religious reasons you cannot sign this, please contact the camp for a waiver, which must be signed for attendance.*