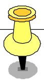


Grandparent & Me Camp

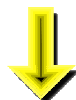
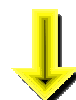
Sorry for the inconvenience that online registration is not available. Please use this checklist and following forms to make sure you send in all appropriate paperwork to register by mail.

Following are the forms needed:

- ❑ ***Outdoor Ministries Grandparent & Me Registration Form***
  (along with family deposit of $50.00)

- ❑ ***Health History Record***
  (2 pages – **YOUTH only**)

- ❑ ***Adult Permission & Health Statement***
  (1 for each adult attending the event)

 **Hard Copy Registration Forms** 

Please **PRINT or TYPE** the following information:

Pilgrim Park Events	Tower Hill Events
#105 Grandparent & Me Camp – June 14-16, 2018	#225 Grandparent & Me Camp – June 14-16, 2018
#165 Grandparent & Me Camp – July 5-7, 2018	#230 Grandparent & Me Camp – June 18-20, 2018

❖ Register my family for Grandparent & Me Camp Code # ____________________

❖ Check here if this is your camper's first camp experience at either Pilgrim Park or Tower Hill Camp ☐

Please list family members (If additional space is needed please put on a separate sheet of paper):

Name ______________________ Date of Birth ____/____/____ ☐ Male ☐ Female
Month/Day/Year

Name ______________________ Date of Birth ____/____/____ ☐ Male ☐ Female
Month/Day/Year

Name ______________________ Date of Birth ____/____/____ ☐ Male ☐ Female
Month/Day/Year

Name ______________________ Date of Birth ____/____/____ ☐ Male ☐ Female
Month/Day/Year

❖ 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 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 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 a $50.00 will be held as a service fee.

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 <u>as needed basis</u>*:*

(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.)

Medication	No	Yes	Directions/Dosage
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.*

Revised January 2017

GRANDPARENT & ME CAMP
ADULT PERMISSION & HEALTH STATEMENT

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

Yes No

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

Please print ADULT Participant's name:

First Name: ________________________ Last Name: ___________________________

List any health issues: ____

____

____

List dietary restrictions or food allergies: ____________________________________

____

____

Please compete:

Emergency Contact Person: ____

Day Phone Number: (_________) ____________________________

Evening Phone Number: (_________) _________________________

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 if I am unable to verbally give permission.

X____

Signature *Date*

Revised March 2018