



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

#105 Grandparent & Me Camp – June 13-15, 2019
#165 Grandparent & Me Camp – June 27-29, 2019

Tower Hill Events

#225 Grandparent & Me Camp – June 13-15, 2019
#230 Grandparent & Me Camp – June 17-19, 2019

❖ 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

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression | <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Diabetes (specify) _____ | |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Autism Spectrum (specify) _____ | |
| <input type="checkbox"/> Other (specify) _____ | | | |

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

- | | |
|--|--|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Insect Stings (specify) _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Food Allergy (specify) _____ |
| <input type="checkbox"/> Plants/Pollen | <input type="checkbox"/> Drug Allergy (specify) _____ |
| <input type="checkbox"/> Other Allergies (specify) _____ | |

Other Information

- | | | | |
|---|--------------------------------------|-------------------------------------|--------------------------------------|
| ❖ Camper wears the following: | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Knee Brace | <input type="checkbox"/> Other Brace |
| ❖ Camper has experienced puberty changes: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| ❖ Camper needs assistance walking on uneven ground: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| ❖ Camper has sleep disturbances: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| ❖ Camper has nightmares: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| ❖ Camper sleepwalks: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| ❖ Camper wets the bed: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| ❖ Camper has fears that are outstanding: | <input type="checkbox"/> Yes | <input type="checkbox"/> 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ibuprofen/Advil/Motrin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Naproxen Sodium/Aleve	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diphenhydramine/Allergy/Benadryl	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Antacids/Tums	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Triple Antibiotic Ointment/Neosporin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Topical Hydrocortisone	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Topical Antihistamine/Benadryl Cream	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ear & Eye Drops	<input type="checkbox"/> No	<input type="checkbox"/> 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.

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 complete:

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