

# ILLIANA JUNIOR CAMP

Bedford, Indiana

August 2 – August 6, 2010

Name \_\_\_\_\_ Phone: (home) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Congregation \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_

Cabin Mate Preference (please limit to one name) \_\_\_\_\_ Grade Completed \_\_\_\_\_

## REGISTRATION FEE

Cost of Camp	\$140.00
Western District donation	- 40.00
Moravian Women's Ministries donation	- 5.00
<b>Total Camper Registration Fee:</b>	<b>\$ 95.00</b>

**Early Bird Registration: Pay \$80. Must be postmarked by July 4, 2010.**

(4)

## CAMP T-SHIRT AND PICTURE

The registration fee includes a camp t-Shirt and picture. Please circle your child's T-shirt size below:

Child: Small (6-8)      Medium (10-12)      Large (14-16)  
Adult: Small      Medium      Large      Other (indicate size) \_\_\_\_\_

Please Note: Every camper is required to have a completed Western District Official Health Form. We recommend that you mail the form with your registration, though you may bring it with you to camp. *Copies of the health form are available at your local church office.*

Send this form, the registration fee, and the health form by July 7, 2010, to:

**Beth Etzkorn**  
**22529 E. 1150 Road**  
**Allendale, IL 62410**

**Please make check payable to: Illiana Junior Camp**

**Registrations that arrive after July 7th may not receive a T-shirt.**

Once we have received your registration, we will provide a letter of acknowledgement which will provide additional information to prepare your child/children for a great camp experience including, a list of things to bring, instructions to the camp, and other helpful information.

**CAMP PHILOSOPHY AGREEMENT**

As a participant in a Christian camp experience, I will try to live according to the stated Philosophy. I recognize that individuals living in a group have a need for discipline so that they may grow in mutual understanding and appreciation.

I recognize that discipline takes many forms and that it is most effective when it comes from the individual. But I also feel that at times some form of external authority may be necessary. I shall attempt to abide by both internal and external authority.

I also understand and agree that the possession and/or use of all drugs including alcoholic beverages, marijuana, hallucinogens and all other drugs, except prescription drugs, are prohibited during the entire camping experience – this means from the time of leaving home until returning home.

It is my hope and goal to apply this experience in Christian growth to my life. I further agree that my registration is my commitment to participate in this program.

\_\_\_\_\_

*Camper Signature*

\_\_\_\_\_

*Date*

**PARENT SIGNATURE AGREEMENT**

The undersigned parent(s) or guardians of a child or children participation in the 2010 Illiana Junior Camp acknowledges the follows:

1. *That they have read the Camp Philosophy Agreement above and agree to have their child/children abide by its principles.*
2. *That they believe their child/children to be physically and mentally capable of participation in all camp activities unless otherwise stated.*
3. *That they understand that Illiana Junior Camp is a Christian learning and recreational activity for their child/children and is not a profit making activity.*

\_\_\_\_\_

*Parent/Guardian Signature*

\_\_\_\_\_

*Date*

**PHOTO/MEDIA WAIVER**

I, being the parent/guardian of, \_\_\_\_\_, hereby consent that his/her image, and likeness, as shown in video-tapes, photographs, and/or electronic images in he/she appears, and/or audio recordings made of his/her voice may be used by the Moravian Church for Camp Promotions or posted on the official camp web page.

\_\_\_\_\_

*Parent/Guardian Signature*

\_\_\_\_\_

*Date*

**Share Your Gift / Talent Night**

We are planning a "Share Your Gift" event for campers and staff alike for our Wednesday evening program. There will be an opportunity for those who would like to sing, play an instrument, dance, do a comedy routine, etc. We don't want anyone to feel under pressure to perform, but it's a good opportunity for our young people to share their talent as a gift for others. We do not have safety precaution mats for gymnastics or acrobatic stunts.

**Visitors Policy**

Our policy is to have visitors at drop-off and pick up times only. We encourage parents and visitors to spend time seeing the camp on Monday during registration or Friday during pick-up. In many cases, this week will be a young campers first time away from home. It has been our experience that campers adjust to the camp activities and program quickly on the first day. Every effort is made by staff to help campers overcome feelings of homesickness and feel encouraged by their ability to make new friends. Sometimes having a familiar face suddenly show up during the week can cause a set back in their adjustment. We want to do everything we can to assure the enjoyment of all of our campers.

**Any Other Questions?**

Please contact a member of the Illiana Camp Committee. We would welcome your call.

Beth Etzkorn, Director  
Danny Boewe  
Kurt Heilman  
Steve Sweet

618-299-2502  
812-378-1901  
812-546-5721  
812-662-6741

Email: [betzkorn@verizon.net](mailto:betzkorn@verizon.net)  
Bethany Rotramel 618-456-2026  
Rev. Terry Weavil 618-456-3494

For Office Use

# Health History Form for Children, Youth and Adults Attending Camps FM 11

Suggested for Day Camp Use

Developed and approved by American Camp Association with the American Academy of Pediatrics

Dates of Camp Attendance \_\_\_\_\_

Mail this form to the address below by \_\_\_\_\_ (date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon

participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Year

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street Address City State Zip

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address (if different from above) \_\_\_\_\_  
Street Address City State Zip

Business address \_\_\_\_\_  
Street Address City State Zip

### Second parent or guardian or emergency contact

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

### Insurance Information

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

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

► Photocopy of front and back of health insurance card must be attached to this form.

### Important — These boxes must be complete for attendance\*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician 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.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

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

**ALLERGIES** List all known. Describe reaction and management of the reaction.

**Medication allergies (list)**

\_\_\_\_\_

**Food allergies (list)**

\_\_\_\_\_

**Other allergies (list)** — include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_

Session or Group

Name

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing

physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR  This person **takes medications** as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

**RESTRICTIONS** (The following restrictions apply to this individual.)

Does not eat:  Red meat  Pork  Dairy products  Poultry  Seafood  Eggs  Other (describe) \_\_\_\_\_

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) \_\_\_\_\_

## GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure? .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur? .....             | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 16. Ever had back problems? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Ever had problems with joints (e.g., knees, ankles)? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have an orthodontic appliance being brought to camp? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have any skin problems (e.g., itching, rash, acne)? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have diabetes? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have asthma? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Had mononucleosis in the past 12 months? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Had problems with diarrhea/constipation? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have problems with sleepwalking? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. If female, have an abnormal menstrual history? .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have a history of bed-wetting? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Ever had an eating disorder? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Ever had emotional difficulties for which professional help was sought? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any "yes" answers, noting the number of the questions. \_\_\_\_\_

Which of the following has the participant had?

- Measles  
 Chicken pox  
 German measles  
 Mumps  
 Hepatitis A  
 Hepatitis B  
 Hepatitis C

TB Mantoux Test

Date of last test \_\_\_\_\_

Result:  Positive  Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

### Screening Record (For camp use only)

Screened by \_\_\_\_\_

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am \_\_\_\_\_ pm Updates/additions to health history noted  Yes  No  None required

Meds received \_\_\_\_\_

Current health needs identified \_\_\_\_\_

Observational notes \_\_\_\_\_