



JR. CAMP REGISTRATION FORM
Camp Sunrise Mountain Markleysburg PA

July 20-22 2022 (WED-FRI.)

Please print or type each line of this form.

Camper's Name _____ Male ____ Female ____

Address _____

City _____ State _____ Zip _____

Birth date _____ Age _____ **Grade in Fall 2022** _____

T-Shirt Size (circle one) **Child** S M L **Adult** S M L XL

What church will you come with? _____

Parent(s) or Guardian(s) _____

Primary Phone (____) _____ Other Phone (____) _____

If not same address as above, list _____

In case of emergency, is there someone other than the above to notify?

Name _____ Phone No. _____

Is camper able to participate in all camp programs? (swimming, field games, etc.)

Yes ____ No ____

If no, which type of activities are not permissible? _____

Are your state's required immunizations current? If no, please list those that are not current.

1. Is your youth allergic or sensitive to medicine or inoculations, asthma, hay fever, insect bites, poison oak, any foods, etc. If yes, give details and list medications and food allergies.

2. Some of the youth will be sleeping in the top bunk of bunk beds. Does your youth fall out of bed? ____ Does your youth have nightmares? ____ Please give us the necessary instructions if your youth has any of these problems.

3. Please specify any other information that would be helpful for the adults supervising your youth during Jr. Camp (significant recent illness, accident, health history).

Your camper's health and well-being during camp is of utmost importance to us! For us to treat and properly care for your child, we ask that you fully complete this form even if your child doesn't regularly take prescription or over-the-counter medication. Our camp stock of OTC medicines is limited, so please provide anything you foresee your child needing

during camp. Please Note: All OTC medicines will be given following manufacturer's recommendations. **If your child is younger than 12 and the medicine sent is not recommended for children younger than 12, a signed statement from the child's physician or health care provider authorizing administration of the OTC medicine will be necessary.**

Suggested over-the-counter medicines: something for pain/fever [ex. children's Tylenol or Ibuprofen], something for allergy relief [ex. Benadryl]. You may wish to consult with your child's physician or health care provider regarding what medication[s] to send. **If your child is bringing nasal sprays or inhalers and you wish your child to keep and self-administer them, then written authorization must be received from your child's physician.**

OVER THE COUNTER (OTC) MEDICATIONS:

** A Parent or Legal Guardian may provide Camp with OTC medications. Please list the medications you plan to send for your child and the reason(s) why your child should take them. All medication will be kept by the Camp Staff. It must be in the **original manufacturer's container** with the camper's name written on the container. OTC medicines will be administered following manufacturer's guidelines.

Name of OTC Medicine Reason(s) for Giving

Tylenol 160 mg (example) According to manufacturer (example)

My child should not take the following OTC medications:

PRESCRIPTION MEDICATIONS: The following section must be completed by camper's PARENT or LEGAL GUARDIAN. (All medication is dispensed by Camp Staff) **If your child is bringing an EpiPen you MUST talk to your group leader before your child leaves for camp. Campers will NOT be administered any prescribed medicine that is expired, prescribed for someone other than the camper for whom it was sent, or given for any problem other than the original problem for which it was prescribed*

List **all prescription medications** you plan to **send with your child** and the reasons s/he takes them (attach extra sheet if necessary)

Medication: Dosage: Time Given:

Reason:

Medication: Dosage: Time Given:

Reason:

Medication: Dosage: Time Given:

Reason:

Medication: Dosage: Time Given:

Reason:

Your child's medication MUST be in the correct pharmacy prescription bottle w/administration directions on the pharmacy label. Prescription medication label must include: Child's name, Strength of the medication, Amount given, how often it is to be given, and expiration date of the medication.

Your family physician _____

Physician's address _____

Physician's phone number (____) _____

Your insurance company _____

Insurance policy number _____

I, the undersigned am the legal parent and/or guardian of _____, and I give him/her permission to participate in Camp Activities under the supervision of Camp Staff. I also release the EMC and its

representatives from all liability while my child is participating in Camp Activities. I give the EMC and its representatives permission to obtain, in an emergency, medical or surgical care for him/her in the event I cannot be reached and such is necessary. I understand that every effort will be made to locate me in case of such an emergency. I also give permission for the camp staff to provide my child over the counter (OTC) medication (i.e. Aspirin, Ibuprofen, Benadryl, etc) provided by us or the camp staff to treat symptoms such as headaches, allergies, etc. unless otherwise noted and the listed prescription medicines. **Note:** I also understand that photos will be taken of camp activities involving my children which may be used for promotional use of the Jr. Camp and the EMC only in brochures, web sites, slide presentations, denominational publications, etc.

Parent's (or Guardian's) Signature _____

Date _____