

# WISCONSIN CONGREGATIONAL ASSOCIATION CAMP REGISTRATION/CONSENT & HEALTH FORM

## Section 1: To be completed by a parent or legal guardian.

Camper's full name			
Birth date		Gender	
Age as of July 12, 2011		Grade just completed	
Parent(s)/guardian(s)			
Home street address			
City, state, and zip			
Camper's email address		Parent(s) email address(es)	
Home phone			
Work phone			
Other phone (e.g. cell)			
Parent(s) fax #(s)			
Home Church			
Campers T-shirt Size <small>(NEW this year. Each camper will receive a WCA camp shirt included with registration.)</small>	XS	S	M L XL
Emergency contact (name, phone, relationship)			
Emergency contact (name, phone, relationship)			
Name and phone # of camper's primary physician			
Camper's medical insurance carrier & group/policy # <b>(include a photo copy of card)</b>			
Medication allergies and related reactions			
Food allergies and related reactions			
Insect and animal allergies and related reactions			
Any activity restrictions		Any dietary restrictions	
Prescription Medication and dose info (must be brought in original vial form Pharmacy)			
Over the counter Medication and dose info (must be brought in original container)			
Is it OK for the Camp Nurse to give Advil, Tylenol, Benadryl, other?			

If space is insufficient for any response(s), please continue on a separate sheet, and attach it to this form.  
Upon arrival at camp, please provide any changes or updates to the information given above.

**Continued →**

**Section 2: To be completed by a parent or legal guardian.**

<i><b>Has/does the camper:</b></i>	<i><b>Yes</b></i>	<i><b>No</b></i>	<i><b>Explanatory Notes</b></i>
Had any recent injury, illness, or infectious disease?			
Have a chronic or recurring illness or condition?			
Have frequent headaches?			
Wear glasses, contacts, or protective eyewear?			
Ever passed out, or become dizzy, during or after exercise?			
Ever had seizures?			
Ever had chest pain during or after exercise?			
Ever been diagnosed with a heart murmur?			
Have an orthodontic appliance being brought to camp?			
Have diabetes?			
Have asthma, hay fever, or other respiratory condition?			
Had mononucleosis in the past twelve months?			
Have any diarrhea, constipation, or other digestive problems?			
Have problems with sleepwalking?			
Have any history of bedwetting?			
Ever had an eating disorder?			
Ever had emotional issues for which professional help was sought?			
If female, have abnormal menstrual history?			
Had measles?			
Had chicken pox?			
Had German measles?			
Had mumps?			
Had hepatitis — A, B, or C?			

**Section 3: To be completed by a parent or legal guardian.**

<i><b>Immunization</b></i>	<i><b>Yes</b></i>	<i><b>No</b></i>	<i><b>Month &amp; Year of Most Recent Vaccine or Booster Shot</b></i>
DTP			
TD (tetanus and diphtheria)			
Tetanus (if separate from TD)			
Polio			
MMR (measles, mumps, and rubella)			
Measles (if separate from MMR)			
Mumps (if separate from MMR)			
Rubella (if separate from MMR)			
Haemophilus influenza B			
Hepatitis B			
Varicella (chicken pox)			

**Continued →**

**Section 4: To be completed by parent or legal guardian.**

<i>Month and Year of Most Recent TB Mantoux Test</i>	<b>Positive</b>	<b>Negative</b>

*Please use the space below for any additional information about the camper's behavior and physical, emotional, and mental health about which the camp should be aware.*

**Section 5: To be completed by a parent or legal guardian.**

All information provided by me in all sections of this health information form is correct and complete to the best of my knowledge and belief. I authorize a licensed physician, physician's assistant, or nurse practitioner to complete Section 7 of this form. Furthermore, I authorize any and all licensed medical personnel who have ever examined or treated the camper to release records and information for the purpose of facilitating emergency care of the camper, if necessary, during the week of camp.

I hereby certify that I am aware of, approve of, and take full responsibility for the participation of the above named camper in the Wisconsin Congregational Association's summer camp program. Furthermore, I assume all risk of and financial responsibility for any loss or injury to the camper or others that may occur as a result of negligence or misconduct by the camper, and I release the Wisconsin Congregational Association, its member churches, and its employees, volunteers, and other agents, from any and all responsibility and legal liability for loss, damage, or injury to the person or property of the camper which may be sustained during or as a result of participation in the camp program and all related activities.

In the event of an emergency, including illness, injury, or incapacity suffered by the camper during the course of the camp program, I hereby authorize any Wisconsin Congregational Association Camp staff member, or any Mt. Morris Camp staff member, to act as agent for me in consenting to any reasonably necessary X-ray examination, medical, dental, surgical, or psychological diagnosis, treatment, and/or care, advised and supervised by a physician, nurse, dentist, surgeon, psychologist, or social worker licensed to practice under the laws of the state of Wisconsin. I understand that I, or the applicable insurance carrier(s), will be financially responsible for any such emergency services. I expect that attempts will be made to contact me in the event of any such emergency.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

**Section 6: To be completed by the camper.**

I have read all four pages of the WCA Camp Brochure (the outer sheet of this packet), understand its contents, and agree to abide by its instructions. I understand that if I fail to follow these policies and procedures, I may be sent home at my parents' expense. I also realize that my attitude will largely determine the kind of experience that I have at camp, and therefore I will do all that I can to make the week of camp a safe and fun time of recreation and learning for myself and for my fellow campers.

\_\_\_\_\_  
Camper's signature

\_\_\_\_\_  
Date

**Continued →**

**Section 7: To be completed by licensed medical personnel.**

Date you last examined the camper	
Blood pressure	
Height and weight	
In your medical opinion, is the camper able to participate in an active camp program?	
For what conditions is the camper currently under your care?	
Treatment(s) to be continued at camp	
Medication(s) to be administered at camp — name(s), dose(s), and frequency	
Any medically-prescribed meal plan or dietary restrictions	
Any known allergies	
Description of any limitation or restriction on camp activities	
Additional information for the health care staff at camp	

*If space is insufficient for any response(s) please continue on a separate sheet, and attach it to this form.*

\_\_\_\_\_  
Signature of physician, physician’s assistant, or nurse practitioner

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed name of the above signatory

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone # (including area code)

**Section 8: For camp staff use only.**

*Date and time of arrival at camp:* \_\_\_\_\_

	<b>Date</b>	<b>Amount</b>	<b>Balance</b>		<b>Date</b>	<b>Amount</b>	<b>Balance</b>
Deposit Received				Scholarship Received			
Balance Received							
Any changes or updates to previously provided health form information received?							
Other notes:							