Special Session STAFF Registration Form 2008

for entering 11th graders and older

A $50.00 deposit is required for all registrations. The full $130 is due 10 days prior to the beginning of the Session.

Please type or print

Name of Staffer____
Last First Prefer to be called

Circle:Male / Female **Grade Next Fall**___________ **Date of Birth** / / **Age**_____

Have you ever been to Camp McDowell before?_____

Parent Name____ **e-mail:** __________________
Last First

Street Address____
City State Zip

Phone Home___________**Work (Dad)** __________**Work (Mom)** __________**Cell**_______

Emergency Contact________________________________ **Phone**____________________

Are you an Episcopalian? Y / N **If so, what parish?**_________________

If not, what is your religious affiliation?_______________________

T-Shirt Size___________________

REGISTRATIONS WILL NOT BE PROCESSED UNTIL A DEPOSIT OR FULL PAYMENT HAS BEEN RECEIVED AND THE HEALTH FORM HAS BEEN COMPLETED! PLEASE READ NEW OVER-THE-COUNTER MEDICATION PROCEDURES

STAFFER: Please read and sign the following statement. By signing this statement you are agreeing to participate fully in the program and activities offered by Camp.
If accepted, I will participate in the Camp program and follow all the rules. I understand that the use or possession of tobacco, illegal drugs, and/or alcohol will result in my immediate dismissal from camp. I will not bring a cell phone or other communication device.
Camper's Signature_____________________________________ Date / /

PARENTS: Please read and sign the following statement:
In case of emergency, I give permission for the staff of Camp McDowell to select a physician and seek medical treatment for my child. I give permission for my child to receive over the counter medication from the camp nurse following physician guidelines. I give permission for photographs of my child to be used for promotional purposes by Camp McDowell. I understand that I am financially responsible for property damages caused by my child's behavior.
Parent's Signature:____ Date / /

To request a scholarship, please contact Michael Goldsmith at (205-387-1806) or (michael@campmcdowell.com). Please consider making a contribution to the Camp McDowell Scholarship Fund when paying your registration fee.

Camp McDowell
Special Session HEALTH FORM
(All information is confidential—PLEASE PRINT)

Staffer NAME:

____
(Last) (First) (Middle)

Primary Physician: ____________________________ Physician Phone # : (   )
____

Parent/Guardian: Name: ____________________________ Student - Sex: M F Age: ______ Grade:______

(____) _________________________ (____) _________________________ (____) _________________________
(Primary Phone Number—i.e. Home) (Secondary Phone Number—i.e. Cell) (Alternate Phone Number –i.e. Work)

Emergency:____
(NAME) (Relationship to Student) (Day Phone) (Evening Phone)

Student Info: Birth Date: ____________ Tetanus: ______ Height: ______ Weight: _____ Contacts? Yes / No
(Month/Day/Year) (YEAR)

Any Known ALLERGIES to: Type Treatment

Insects: yes / no ____

Food: yes / no ____

Plants: yes / no ____

Animals: yes / no ____

Medicines: yes / no ____

Other: yes / no ____

<u>HEALTH CONCERNS:</u>

Is student on a special diet? **Y / N**
If yes, please explain (what **CAN** they eat as well as what they **CANNOT**)

____

____

Health Problems:____

____

<u>ACCIDENT INSURANCE COVERAGE</u>

Accident Insurance costs are covered in the program fee and protect all campers throughout the program. The maximum benefits are: Sickness, $1000; Accidents, $2500; and Loss of Life, $2500. Parents or guardians are responsible for expenses in excess of these amounts.

PLEASE COMPLETE AND READ THE BACK SIDE OF THIS FORM REGARDING MEDICATIONS WHILE AT CAMP.
PLEASE <u>SIGN</u> THE BACK OF THIS FORM (PG 2)

PRESCRIPTION MEDICATIONS: The following section MUST BE COMPLETED BY Camper's PARENT or LEGAL GARDIAN (All medication is dispensed by licensed nurse)

** If your child is bringing an Epi-Pen you MUST talk to the Nurse before your visit: (205) 387-1806 or rn4cmcd@hotmail.com*

List **all prescription medications** you plan to **send with your child** and the reasons s/he takes them.

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.
Please note: "Administer according to directions" is not acceptable.

Prescription Medication LABEL must include:
Your child's name
Strength of the medication
Amount Given
How often it is to be given
Expiration date of the medication

If your child's prescription medication is not in its original container and labeled properly the McDowell Nurse cannot administer it.
If you have further questions please contact the Nurse at (205)387-1806 or rn4cmcd@hotmail.com. Thank You!

All over-the-counter (OTC) medicines must be provided by the parents or legal guardians of the camper

OVER THE COUNTER (OTC) MEDICATIONS:

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

Name of OTC Medicine	Reason(s) for Giving
Tylenol (EXAMPLE)	Fever, Aches, and Pain (EXAMPLE)

Attach Additional Sheets if Necessary

I authorize the Camp Nurse the task of assisting my child in taking the above medications. OTC medicines will be administered following manufacturer guidelines. **** I understand that if my child is younger than 12, a signed statement from the child's physician or health care provider authorizing administration of the OTC medicine will be necessary if the medicine sent is not recommended for use in children younger than 12.** I also
authorize the Camp Nurse to talk with my child's physician or pharmacist should a question come up about the medicine."
All health information is considered confidential and will be shared only on a need-to-know basis to ensure the safety of your child.
This is to certify that the information provided on this form is accurate to the best of my knowledge.

____ ___________________
SIGNATURE OF PARENT or LEGAL GUARDIAN **DATE**

EFFECTIVE DATES (Dates of Camp Session): __________________
Camper Name: ____________________________