



2017 Mid-America Disciples Summer Ministry Registration and Health History

Brochure, Schedule & Forms online: (www.mid-america-disciples.org/summer/)



Complete a separate registration form for each event – return form to your Disciples congregation or to CCMA Registrar (address on next pg)

CROWDER MOVAL NEOLA FAITH ADVENTURES TRIPS CRY@DRURY

CAMP/EVENT NAME: _____ CAMP/EVENT START DATE: _____

T-Shirt Size: (circle one) Youth S Youth M Adult S Adult M Adult L Adult XL Adult XXL Adult XXXL

Check Yes/No: First Time Camper? Yes No First Time CRY Attendee? Yes No Does Participant Swim? Yes No

List any Person(s) NOT ALLOWED to pick up your child from camp/event: _____

Reason: _____

123 Go, Elementary, Junior Camper cabin-mate request (1 name only/must be mutual): _____

Participant Name: _____ Date of Birth: _____

*Gender: _____ (Mark on health form any info regarding identity) Age: _____ Grade Completed by 6/30/2017: _____ YR of HS Graduation: _____

Participant Address: _____ City/State/Zip: _____

Home Telephone: () _____ Participant E-mail Address: _____

Local (DOC) Congregation & City _____ Pastor's Name _____

Church or Pastor's Email Address: _____

Mother/Guardian's Name: _____ E-mail: _____

Complete Address (if different from Participant): _____

Daytime Phone: () _____ Cell/Other Phone: () _____

Father/Guardian's Name: _____ E-mail: _____

Complete Address (if different from Participant): _____

Daytime Phone: () _____ Cell/Other Phone: () _____

If Parents/Guardians are unavailable in emergency, notify (name): _____

Relationship to Participant: _____

Daytime Phone: () _____ Cell/Other Phone: () _____

Releases and Authorizations: please check to be sure all signatures (3) and initials (3) are completed below and notarization if needed

This Registration & Health History is correct and complete as far as I know. The person herein named as "participant" has permission to engage in all activities except as noted. I hereby give permission to event leaders to provide, seek, and consent to routine health or dental care, administration of prescribed medication, and emergency treatment for me/my child, as may be deemed necessary, including but not limited to x-rays, routine tests, and treatment, and/or hospitalization. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that event leaders be treated as acting *in loco parentis* if the person herein named is a minor. Further it is my intention that the appropriate event representatives be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the Health Insurance Portability and Accountability act of 1996. I hereby agree (pursuant to 45CFR§164.510(b)) to the disclosure to these representatives of the protected health information of the person herein described, as necessary; (1) to provide relevant information to event representatives related to the person's ability to participate in activities; and (2) in the case of minors, relevant information to event representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by event leaders to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Please initial Medication, Transportation and Photography Releases:

- _____ We/I authorize staff to administer over-the-counter medication to my child for minor pain, headache, upset stomach, sore throat, cold symptoms, or allergy.
- _____ We/I give permission for our/my child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Mid-America Disciples (DOC) Summer Ministry.
- _____ We/I give permission for our/my child to be photographed, video or audio taped and understand that these photos, videos, or recordings may be used in Mid-America of the Christian church (DOC) newsletters, promotion or other print, digital or internet publications.

Signature of Custodial Parent/Guardian (or Adult Camper/Staff) _____

Printed Name _____ Date _____

Participant Covenant: I covenant with my Creator, event staff, and other participants to do my best to:

- Expect the best of others, and give my best in our activities together.
- Participate fully in activities and attend the entire event.
- Abide by rules, policies, and expectations of the camp/event.
- Expect to make new friends, be a friend to others, and have fun.
- Respect event property and personal belongs of participants and staff.
- Respect each person's dignity, affirming that each one is created VERY GOOD, in the image of God.
- Be a good steward of creation, appreciating and caring for the environment.
- Grow in my relationship with Jesus Christ, through prayer, Bible study, worship and fellowship.
- Create a community of hospitality and inclusion that honors the unique contributions of each person.

Participant's Signature _____ Date _____

Pastor's Recommendation: I recommend this individual for participation in Mid-America Disciples (DOC) Summer Ministry.

Pastor's Signature _____ Date _____

Canoe, Trek, & Backpacking Trip Forms for minors must be notarized

Subscribed and sworn before me, _____

Notary Public for _____ County, Missouri

on this _____ day of _____

Notary Public Signature _____

FOR Office ONLY!!!

- Excel ACTIVE COPIED Ck#
 Church paid Individual paid

Health History for
(Participant name): _____

Date of Last
Physical Exam _____

Insurance Information: Is the participant covered by medical /hospital insurance Yes No Date of Last Tetanus _____

If so, list carrier or plan name: _____ Policy/Group #: _____

Physician: _____ Phone: () _____

Dentist/Orthodontist: _____ Phone: () _____

ALLERGIES List all known Include medicines, food, insect stings or bites, hay fever, asthma, animal, etc.	Describe reaction and management of reaction If more space is needed, please attach an additional sheet
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DIET, NUTRITION: This participant eats a regular diet. This participant eats regular vegetarian diet. This participant has special food needs.
 Please describe any special dietary needs below. If additional space is needed, please attach an additional sheet.

MEDICATIONS BEING TAKEN Please list all medication (including over-the-counter or non-prescription drugs) Bring enough medication to last entire camp/event. All medication must be in the original package that identifies the patient, prescribing physician (if prescription drug), name of the medicine, dosage and frequency of administration. If more space is needed, please attach an additional sheet.

Medication & Dosage.	When given & reason for taking medication
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Camper Height _____ Camper Weight _____

General Health: Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet if needed. For travel outside country, please name countries visited.

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Has or does the participant: | YES | NO | Has or does the participant: | YES | NO |
| 1. Had a recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have asthma/wheezing/shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Ever had back/joint problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have any skin problems (e.g. itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Had mononucleosis ("mono") in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Issues regarding gender identity? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Had fainting or dizziness? | <input type="checkbox"/> | <input type="checkbox"/> | 17. If female, have problems with periods/menstruation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had seizures or convulsions? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have a history of bedwetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever passed out/had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Traveled outside the country in the past 9 months? | <input type="checkbox"/> | <input type="checkbox"/> |

Mental, Emotional and Social Health Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet if needed.

- Has the participant:**
- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Had a significant life event that continues to affect the camper's life?
(history of abuse, death of a loved one, family change adoption, foster care, new sibling, survived a disaster, other...) | <input type="checkbox"/> | <input type="checkbox"/> |

What have we forgotten to ask? Use this space to provide any additional information about the participant's health or behavior that you think important or that may affect his/her ability to participate fully in the camp/event. If more space is needed, please attach an additional sheet.

Return completed, signed form with the items 1-3 to your local church if Disciples. All others, return items to CCMA Registrar PO Box 1 Lathrop, MO 64465

- 1) Copy of Immunization Record (must include dates); 2) Copy of front and back of insurance card; 3) Payment of fee - make check out to your local church

Note: Canoe, Trek & Backpacking Trip Forms for minors must be notarized.