



Try-It Camp Registration Form 2017 NEOLA Disciples Camp

Questions? Contact the Mid-America Registrar: 816-632-2237, ccma.doc.jan@gmail.com

Return form and fees to your Disciples church, or

CCMA Registrar

NEOLA

P.O. Box 1

400 Center Street

Lathrop, MO 64465

Please complete one form for each family unit

First and Last Name	<input type="checkbox"/> Adult (over 18)	<input type="checkbox"/> Child	Child's Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Tetanus
First and Last Name	<input type="checkbox"/> Adult (over 18)	<input type="checkbox"/> Child	Child's Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Tetanus
First and Last Name	<input type="checkbox"/> Adult (over 18)	<input type="checkbox"/> Child	Child's Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Tetanus
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First and Last Name	<input type="checkbox"/> Adult (over 18)	<input type="checkbox"/> Child	Child's Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Tetanus

Address	Phone
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City	State	Zip
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Email Address	Best Method of Contact: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> US Mail
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Special Requests (For example, "We want to share a cabin with [name] family.")	<i>We will do our best to honor special requests. They will be fulfilled in the order received.</i>
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Camp T-shirts (1 per person)	Youth S	Youth M	Adult S	Adult M	Adult L	Adult XL	Adult XXL	Adult XXXL
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Housing Options for Try-It Camp*

Prices are for 1 adult /1 child combination in cabin, with an option for either one extra single adult or extra child. For one adult/child pair, write "1" in the appropriate box (lodge or cabin). For singles, write the number of individual extras on the appropriate line (lodge or cabin). For example, for a family of four (2 adults and 2 youth) registered by 5/1, write "2" in the \$180 box. Total = \$360. For a family of three (1 adult/child pair + 1 child registered by 5/1, write "1" in the \$180 box and "1" in the child box. Total = \$235. **Questions??** Email ccma.doc.jan@gmail.com or call 573.442.5815.

Cabin Housing:	<input type="checkbox"/> Adult + child pair \$180 (by 5/1/2017)	<input type="checkbox"/> Adult + child pair \$205 (after 5/1/2017)	<input type="checkbox"/> Add'l Adult \$70	<input type="checkbox"/> Add'l Child \$55	Total for Cabin:	\$
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* Fee includes housing, meals and all program expenses for Friday dinner—Sunday breakfast.

Releases and Authorizations: *please sign and initial as directed*

This Registration & Health History is correct and complete as far as I know. The person herein named as “camper” has permission to engage in all camp activities except as noted. I hereby give permission to the camp 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 the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further it is my intention that the appropriate representatives of the camp 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 camp representatives of the protected health information of the person herein described, as necessary; (1) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; and (2) in the case of minors, relevant information to the camp 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 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.

Please initial Transportation, Photography, and Medication Releases:

- 1.____ 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 the Northeast and Ozark Lakes Areas of the Christian Church (DOC).
- 2.____ 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 Northeast and Ozark Lakes Areas newsletters, promotion or other print, digital or internet publications.
- 3.____ I authorize camp staff to administer over-the-counter medication to my child for minor pain, headache, upset stomach, sore throat, cold symptoms, or allergy.

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

Date

Printed Name

Participant’s Covenant

As a family, we covenant with our Creator, the camp staff, and other campers to do our best while at camp to:

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

Family Representative’s Signature

Date

Return this completed, signed form with the items below to your local church:

- Completed Try-It Health form for each person attending camp
- Camp fees (make check out to your local church)

**Questions?? Contact the CCMA Registrar at ccma.doc.jan@gmail.com or 816-632-2237
CCMA Registrar, P.O. Box 1, Lathrop, MO 64465**

2017 NEOLA Try-It Camp Health History (complete one for each individual)

Camper Name: _____ **Date of Last Physical Exam** _____

Insurance Information: Is the participant covered by medical /hospital insurance Yes No

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 camper eats a regular diet. This camper eats regular vegetarian diet. This camper has special food needs.
 Please describe any special dietary needs below. If additional space is needed, please attach an additional sheet.

MEDICATIONS BEING TAKEN ATCAMP (including vitamins and over-the-counter or non-prescription drugs)
 If you are staying in lodging with just your family, you may keep and administer medications yourself. If you are sharing lodging with adults or children other than your own family, medication must be checked in to the camp medic/nurse and will be administered by camp medical staff. 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.

GENERAL HEALTH: Check YES or NO for each statement. Please explain YES answers below, noting the number of the question, attach an additional sheet or write on back of this form if more space is needed. For travel outside country, please name countries visited.

Has or does the camper:	YES	NO	Has or does the camper:	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. Had headaches?	<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 or write on back of this form if more space is needed.

Has the camper:	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 affects the camper? (abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Had a loved one serving in the military (currently or in the recent past)?	<input type="checkbox"/>	<input type="checkbox"/>

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