

JR. CAMP REGISTRATION FORM

Camp Sunrise Mountain Markleysburg PA

Sponsored by Faith Country Chapel and Covenant Church

July 10-12, 2024 (Wed-Fri)

Camper's Name _____ Male ____ Female ____

Address _____

City _____ State _____ Zip _____

Birth date _____ Age _____ **Grade in Fall 2024** _____

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? _____

1. Allergies:

2. Sleeping on top bunk ok?

Nightmares or any other sleep concerns we should be aware of?

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 the relevant sections of 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 the 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. If your child is bringing nasal sprays or inhalers and you wish your child to keep and self-administer them, then written authorization from the child's parent/legal guardian must be given to your group's leader.

OVER THE COUNTER (OTC) MEDICATIONS:

Please list the medications you plan to send for your child and the reason(s) why your child should take them. All the 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 the manufacturer's guidelines.

Name of OTC Medicine/Reason(s) for Giving

Example: Tylenol 160 mg/According to manufacturer

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. Please Note: We may or may not have a volunteer nurse on staff. Staff will give according to the instructions provided.*

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:

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Reason:

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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 **Sponsoring Churches** and their representatives from all liability while my child is participating in Camp Activities. I give the **Sponsoring Churches** 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.

Parent's (or Guardian's) Signature _____

Date _____