

2019

Iowa Kids Camp
Registration Form



Iowa Kids Camp 2019

Registration & Health Form

Iowa Kids Camp requires every camper and staff member to complete a health form before attending camp. All health form information is kept confidential and any private health information will be used by the health service staff (or emergency medical personnel). Please complete the following form in its entirety.

1. CAMPER AND FAMILY CONTACT INFORMATION

Full Name: _____	Date of Birth: _____	Age: _____
Name you prefer to be called (if different): _____	Grade Completed: _____	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Mailing Address: _____	
City _____	State _____	Zip _____
T-Shirt Size (circle one): Youth: SM MED LG <i>or</i> Adult: SM MED LG XL		
May Camper Sleep on Top Bunk? (Circle one)	Yes No	Church you attend _____
Primary Caregiver Name: _____	Relationship _____	
Mailing Address: _____		
City: _____	State: _____	Zip Code: _____
Best Number to Contact you _____		
Email address you check frequently: _____		

2. EMERGENCY CONTACTS (please provide two additional people, different from the parent/guardian listed above)

First Contact's Name: _____ Relationship: _____
Best Number to Contact: _____ - _____ - _____

Second Contact's Name: _____ Relationship: _____
Best Number to Contact: _____ - _____ - _____

3. INSURANCE INFORMATION (please attach a photocopy of the front/back of health insurance card)

Health Insurance Information: Provider _____ Group # _____
Policy # _____ Policy Holder's Name _____

4. HEALTH INFORMATION

Name of Doctor: _____ Doctor's Phone Number: _____
Name of Dentist: _____ Dentist's Phone Number: _____
Last visit date of the doctor: _____ Last physical exam: _____
Hospitalized recently: _____ Why? _____
Wears a Medic Alert ID: No Yes/Why? _____

Immunizations: Record the month and year of the camper's immunization record or supply a copy of waiver

Diphtheria, Pertussis, Tetanus (DPT) _____	Varicella (Chicken Pox) _____
Tetanus Booster _____	Tuberculin (TB) _____
Measles, Mumps, Rubella (MMR) _____	

ALLERGIES: Check all known allergies that apply, and circle the reaction:

<input type="checkbox"/> Hay Fever /trees/grass Reaction _____	<input type="checkbox"/> Food Type: _____ Reaction _____
<input type="checkbox"/> Poison Ivy/Oak Reaction _____	<input type="checkbox"/> Food Type: _____ Reaction _____
<input type="checkbox"/> Insect Stings Reaction : _____	<input type="checkbox"/> Other: _____ Reaction _____

MEDICAL HISTORY: Check the all the items below for the camper history or known injury/illness. (Please check all that apply).

- | | |
|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Frequent Stomachaches |
| <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Seizure Disorder or Convulsions | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Joint problems (knees, ankles) |
| <input type="checkbox"/> Wears glasses or contacts | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Attention Deficit Hyperactivity Disorder |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Dizziness during or after exercise | <input type="checkbox"/> Homesickness |
| <input type="checkbox"/> Chest pain during or after exercise | <input type="checkbox"/> Recent injury or injury _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic or recurring illness |
| <input type="checkbox"/> Low Blood Sugars (Hypoglycemia) | <input type="checkbox"/> Other special needs: _____ |
| <input type="checkbox"/> High Blood Sugars (Hyperglycemia) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diarrhea or constipation | |

Additional information: _____

Provide instructions to health staff to manage or care for the items checked above: _____

Physical Activities to be limited or restricted while at camp: _____

6. MEDICATION All medications (includes prescriptions, over-the-counter, inhalers, vitamins or creams) taken while at camp require consent for health center staff/camp nurse to distribute and/or administer any medication. All medications to be administered will be reviewed during camp registration.

Will the camper be taking any medications (includes prescriptions, vitamins, over-the-counter, inhalers or creams)? Yes No
Initial all over-the-counter medications (or equivalent) the Health Service Staff/camp nurse may administer in the event of a need. Medications are required to be initialed for camper to receive the medication according to label directions.

<input type="checkbox"/> Tylenol 325 mg (adult) 1-2 tabs every 4-6 hr <input type="checkbox"/> Tylenol 160 mg (Jr) 2 tabs every 4-6 hr <input type="checkbox"/> Ibuprofen (Motrin) 200 mg 1-2 tabs every 4-6 hr <input type="checkbox"/> Motrin 100 mg (Jr) 2 tabs every 6-8 hr	<input type="checkbox"/> Cortisone Cream topical every 4-6 hr as needed <input type="checkbox"/> Ivarest (Poison Ivy) Cream topical every 4-6 hr as needed <input type="checkbox"/> Calamine Lotion topical every 4-6 hr as needed <input type="checkbox"/> Benadryl Anti-itch Cream topical every 4-6 hr as needed <input type="checkbox"/> Triple antibiotic Ointment topical as needed
<input type="checkbox"/> Claritin (Loratadine) 10 mg 1 __tabs every 12 hr. <input type="checkbox"/> Zyrtec (Cetirizine) 10 mg __tabs every 24 hr. <input type="checkbox"/> Benadryl 25 mg __caps every 6 hr <input type="checkbox"/> Benadryl Elixir (25 mg/tsp) __tsp. every 6 hr <input type="checkbox"/> Cough drops 1 drop every hour	<input type="checkbox"/> Tums (Calcium Carbonate) (antacid) 2 tabs every 4-6 hr <input type="checkbox"/> *Loperamide (Diarrhea) 2mg 2 initially, then 1 after next loose BM * <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____

List ALL prescription medications to be administered during camp by health staff/camp nurse.

Medication Name: Dose: Time Taken: Reason for medication: Doctor:	Medication Name: Dose: Time Taken: Reason for medication: Doctor:
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7. ACCIDENT WAIVER AND RELEASE OF LIABILITY

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.

I certify that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity. *I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.*

I acknowledge that this Accident Waiver and Release of Liability Form will be used by the event holders, sponsors, and organizers of the activity in which I may participate, and that it will govern my actions and responsibilities at said activity.

In consideration of my application and permitting me to participate in this activity, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: The IOWA KIDS CAMP, and/or their directors, health services staff, camp nurse, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

I authorize camp health staff to provide and administer first aide to my camper for minor injuries (minor cuts/scrapes, insect stings, ect.). I understand that in the case of a life threatening or serious emergency, every effort will be made to contact a parent/guardian prior to treatment. If a parent or guardian cannot be reached, however, and the situation requires immediate emergency attention as determined by camp staff, I hereby authorize representatives of the camp to obtain emergency treatment for my child as deemed necessary by representatives of the camp. I agree to the release of any records necessary for treatment or referral of the minor child. **MEDICATION, PRESCRIPTIONS:** Iowa Law **requires** parental authorization to administer any prescription medications brought by campers. **Prescribed medication MUST be in its original container with the pharmacy label showing camper's name, date filled, physician name, medication name, and dose.** I authorize the camp health care staff to administer any prescribed medication being brought to camp.

NON-PRESCRIPTION MEDICINES: I authorize the health care staff or designated First Aide Responder to administer the nonprescription medications that I have INITIALED above in brand name or generic form if necessary, for camper's comfort. **ANY MEDICATIONS NOT INITIALED BY PARENT/GUARDIAN WILL NOT BE ADMINISTERED TO CAMPER.**

I acknowledge that this activity may involve a test of a person's physical and mental limits and carries with it the potential for death, serious injury, and property loss. The risks include, but are not limited to, those caused by terrain, facilities, temperature, weather, condition of participants, equipment, vehicular traffic, lack of hydration, and actions of other people including, but not limited to, participants, volunteers, monitors, and/or producers of the activity. These risks are not only inherent to participants but are also present for volunteers.

I understand while participating in this activity, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Signature
(Please print legibly.)

Date

Participant's Name

Age

Parent/Guardian Signature
(If less than 18 years old, Parent or Guardian must also sign.)

Date

Please mail this form with your (\$20) deposit or full payment by May 24 to Iowa Kids Camp 707 East Euclid Ave Indianola, IA 50125. All forms not postmarked by May 24 will not receive the Early Bird rate of \$180.00 but instead will pay \$200.00. After June 7 Camp will cost \$210.00. There is a multi- kid discount of \$40 per child after the first from the same family. You can also register online at iowakidscamp.com Extra Fees do apply to pay online