SPJST Camp Application

Year 2009

District ______

Each camper must submit an application completed by the camper's parent/legal guardian and notarized. The application must be received by the District Youth Counselor no later than 20 days prior to the district's beginning camp date. Any changes to this form should be provided to camp health personnel upon camper's arrival in camp. Provide complete information so that the camp can be aware of the camper's needs.

Camper Name ______________________________ Birthday ____/____/____ Age at Camp______
Last *First* *Middle*

Home Address____
Street Address *City* *State* *Zip*

Camper's Email Address ______________________________ Gender: ❑ Male ❑ Female

Custodial parent/guardian ______________________________ Phone (____)________________

Home address______________________________ Mobile (____)________________
(If different from above) *Street Address* *City* *State* *Zip*

Business Address______________________________ Phone (____)________________
Street Address *City* *State* *Zip*

Second parent/guardian or emergency contact ____________________ Phone (____)________________

Home address______________________________ Mobile (____)________________
(If different from above) *Street Address* *City* *State* *Zip*

Business Address______________________________ Phone (____)________________
Street Address *City* *State* *Zip*

If not available in an emergency, notify____________________ Phone (____)________________
Relationship______________________________ Mobile (____)________________
Home Address______________________________ Bus. Phone (____)______________
Street Address *City* *State* *Zip*

Lodge ______

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities (horseback riding, canoeing, swimming, etc.) except as noted on this forms's reverse side.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine test. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child I authorize and release the camp director or camp nurse to seek and obtain reasonable and necessary medical care for the camper in the event of an emergency and hereby authorize and release any medical professional and such assistants as such medical professional may designate to provide such reasonable and necessary medical attention without first requiring my knowledge or consent, either verbal or written.

I agree to furnish my child with transportation to and from the campsite. I have read the camp rules and regulation and agree to cooperate with the camp management. I understand that reasonable precautions are taken for the health and safety of all campers. I will not hold the SPJST or any staff members responsible in case of accident. I agree that I am responsible for any damages caused by my child during his/her camping period. I agree that the SPJST accepts absolutely no responsibility for any loss or damage to any camper's property incurred during the camping session or while in transit.

I hereby give my permission for my child to leave the camp grounds to participate in camp programs. The SPJST reserves the right to request that a parent or guardian remove a camper from the camp in the event that he/she causes problems affecting the experiences of the other campers, chaperones, or camp staff. This will be done at the sole discretion of the camp director. I have read and agree to the SPJST Rules of Conduct. SPJST has my permission to use photographs or videotapes of camp activities in which my child may appear in the interpretation of its camping programs to the community.

Parent/Legal Guardian's Signature ______________________________ Date ________________

THE STATE OF TEXAS X
COUNTY OF ____________________ X

BEFORE ME, the undersigned authority, on this day personally appeared ______________________ (Parent/Legal guardian), who by me being duly sworn, states and acknowledged in my presence that he/she signed it for the purposes and consideration therein expressed, and that it is true and correct.

SWORN TO AND SUBSCRIBED BEFORE ME on this ____________day of ________________, 20_____.

____
Notary Public, State of Texas

Typed/Printed Name ______________________________

Name ______

I agree to cooperate with camp chaperones and staff and my fellow campers. I also agree to observe all camp rules and to contribute to a good experience for myself and the entire camp community. I have read and agree to the SPJST Rules of Conduct.

Camper's Signature ______________________________ Date ________________

Allergies

List all Known. Describe reaction and management of the reaction.

Medication Allergies (list)

______________________ ____

______________________ ____

Food Allergies (list)

______________________ ____

______________________ ____

Other Allergies (list) - Include insect stings, hay fever, asthma, animal dander, etc.

______________________ ____

______________________ ____

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

❏ This person takes **No medications** on a routine basis.

❏ This person takes medications as follows:

Med #1 __________________ Dosage ________ Specific times taken each day ________________

Reason for taking ____

Med #2 __________________ Dosage ________ Specific times taken each day ________________

Reason for taking ____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: ______

____

Restrictions

(The following restrictions apply to this individual.)

Does not eat: ❏ Red Meat ❏ Pork ❏ Dairy Products ❏ Poultry ❏ Seafood ❏ Eggs ❏ Other (describe) _________

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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____

General Questions

(Explain "yes" answers below.)

Has/does the participant:

Question	Yes	No
1. Had any recent injury, illness or infectious disease?	❏	❏
2. Have a chronic or recurring illness/condition?	❏	❏
3. Ever been hospitalized?	❏	❏
4. Ever had surgery?	❏	❏
5. Have frequent headaches?	❏	❏
6. Ever had a head injury?	❏	❏
7. Ever been knocked unconscious?	❏	❏
8. Wear glasses, contacts or protective eye wear?	❏	❏
9. Ever had frequent ear infections?	❏	❏
10. Ever passed out during or after exercise?	❏	❏
11. Ever been dizzy during or after exercise?	❏	❏
12. Ever had a seizures?	❏	❏
13. Ever had chest pain during or after exercise?	❏	❏
14. Ever had high blood pressure?	❏	❏
15. Ever been diagnosed with a heart murmur?	❏	❏
16. Ever had back problems?	❏	❏
17. Ever had problems with joints (ex., knees, ankles)?	❏	❏
18. Have an orthodontic appliance being brought to camp?	❏	❏
19. Have any skin problems (ex. itching, rash, acne)?	❏	❏
20. Have diabetes?	❏	❏
21. Have asthma?	❏	❏
22. Had mononucleosis in the past 12 months?	❏	❏
23. Had problems with diarrhea/constipation?	❏	❏
24. Have problems with sleepwalking?	❏	❏
25. If female, have an abnormal menstrual history?	❏	❏
26. Have a history of bed-wetting?	❏	❏
27. Ever had an eating disorder?	❏	❏
28. Ever had emotional difficulties for which professional help was sought?	❏	❏

Please explain any "yes" answers, noting the number of the questions. ______________________________

____

Which of the following has the participant had?

- ❏ Measles
- ❏ Chicken pox
- ❏ German measles
- ❏ Mumps
- ❏ Hepatitis A
- ❏ Hepatitis B
- ❏ Hepatitis C

TB Mantoux Test

Date of Last test ________

Result: ❏ Positive ❏ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	________	________	________	________	________	________
TD (tetanus/diphtheria)	________	________	________	________	________	________
Tetanus	________	________	________	________	________	________
Polio	________	________	________	________	________	
MMR	________	________				
or Measles	________	________				
or Mumps	________	________				
or Rubella	________	________				
Haemophilus influenza B	________	________	________	________		
Hepatitis B	________	________	________			
Varicella (chicken pox)	________	________				

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician ____ Phone ____________________

Address ____

Name of family dentist/orthodontist ______________________________________ Phone ____________________

Address ____