



# SPJST Camp Application

Year 20\_\_

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 form'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 campsites. 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)

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### Food Allergies (list)

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

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## 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)

## General Questions (Explain "yes" answers below.)

Has/does the participant:

**Yes No**

**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. \_\_\_\_\_

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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 \_\_\_\_\_