

For Office Use Only	
_____	Received
_____	Chk. #
_____	Amount Paid
_____	# on Check
_____	Meds



Sponsored by:
Emmanuel Baptist Church
 2200 Eleventh Ave. Lewiston, ID 83501 208-305-3339 208-305-3226
 June 18-22, 2018

<p>Return Completed Application to: Emmanuel Baptist Church Attn: RFKC 2200 11th Avenue Lewiston, ID 83501</p> <p>Please enclose a photo of the camper.</p>

CAMPER REGISTRATION FORM

Instructions: *Please Print.* This form must be completely filled out. The information is vital to the health and well being of the child. Your application will be returned to you if it is not completely filled in.

Child's Last Name _____ First Name _____ Preferred Name _____ Sex _____ Birthdate _____

Street _____ Age _____ Current Emotional Age _____

City _____ Zip _____ School _____ Grade _____ Reading level _____

The child is living with: (Check one) Foster Parent Group Home Relative

Name(s) of person(s) the child is living with _____

(_____) _____ (_____) _____
 Home Phone: _____ Work Phone _____

Emergency Contact _____ (_____) _____
 Phone _____

Relationship to Child _____

Social Worker _____ (_____) _____
 Day Phone Number _____

Moved in Foster Placement how many times? _____

Explain any unusual family circumstances that make camp especially important for the child:
 (for example: recent crisis, being moved in foster placement, severe economic needs, etc.)

CAMPER'S EMOTIONAL/BEHAVIORAL HISTORY

	Often	Sometimes	Not at all		Often	Sometimes	Not at all
Aggressiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Terrors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runs Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning & Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details from above: _____

CAMPER DETAILS:

This child's swimming ability is: Good Poor Do not Know
Learning Disabilities: Yes No Reading Level: _____
Has the child attended a Royal Family Kids Camp before? Yes, where? _____ No
Camper T-Shirt Size: Child Small Child Medium Child Large Adult Small Adult Medium Adult Large

HEALTH HISTORY

Indicate all known allergies, illness, disabilities, physical limitations or medical complications:

Allergies _____

Illnesses/medical complications _____

Disabilities/Limitations _____

Leg or Arm Braces Hearing Aids Eating Disorder Yes No

Indicate date of illness, severity, complications, and any residual impairment.

Respiratory Problems _____	Hypoglycemia _____	Musculoskeletal Allergies _____
Heart or Circulation _____	Dizzy Spells _____	Foot _____
Pulmonary Edema _____	Back _____	Seizure Disorders _____
Hay Fever _____	Anaphylactic Shock _____	Poison Oak _____
Balance Problems _____	Diabetes _____	Fainting _____
Insect Bites _____	Drug Allergy _____	Other _____

Details from above: _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

IMMUNIZATION HISTORY:

Please fill in dates of basic immunizations and most recent booster as best as you can.

DTP Series _____ Booster _____	Tetanus Booster _____	Polio OPV (Sabin) _____
Typhoid _____	Measles Vaccine (live) _____	Tuberculin (TB) Test _____
German Measles (Rubella) _____	Mumps Vaccine (live) _____	Small Pox _____

PRESCRIPTION MEDICATIONS: All medication sent to camp must be in original container with the pharmacy label on it.

Is your child taking any medications? No Yes, please fill in the following

1. Name _____ Dosage: _____ Times: _____

2. Name _____ Dosage: _____ Times: _____

3. Name _____ Dosage: _____ Times: _____

What is(are) the medication(s) for: _____

Doctor's Name _____ Phone _____

Please add any other comments related to HEALTH and MEDICATIONS on an additional sheet.

I understand that it is my responsibility as caregiver to make sure that all instructions are clear and that the necessary dosage is adequately supplied for the duration of camp. I hereby authorize RFKC's nurse to administer the above medication from _____ to _____.
Day/Date Day/Date

Parent or Legal Guardian Signature

Printed Name

Date

MEDICAL RELEASE FORM:

This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of Royal Kids Camp or such substitute as they may designate as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is en route to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Director of Royal Family as legal guardian/social worker/other. I give my permission for _____ Camper to attend Royal Family Kids' Camp in the summer of _____ Year through [church name].

Authorized Signature _____ Printed Name _____ Date _____

Child's Medicaid # _____ Signature: _____

Relationship to child: _____ Date _____

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

I hereby give the Royal Family Kids' Camp Registered Nurse permission to administer the following products according to manufacturer's instructions, or as otherwise specified.

I trust the RFKC Registered Nurse to use her best judgment as situations arise, and if in doubt, he/she can call for verification.

Please check YES or NO for the medications listed below. This form must be completely filled out by the primary caregiver who signs below, or camper may not attend camp.

YES	NO		Specify if desired:
<input type="checkbox"/>	<input type="checkbox"/>	Sunblock	_____
<input type="checkbox"/>	<input type="checkbox"/>	Insect repellent	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lip balm	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rash ointment	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tylenol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Antiseptic ointment	_____
<input type="checkbox"/>	<input type="checkbox"/>	Band-aids	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anti-itch cream	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hydrogen peroxide	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cough syrup	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cough drops	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decongestant	_____
<input type="checkbox"/>	<input type="checkbox"/>	Antihistamine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ipecac syrup	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

Parent or Legal Guardian's Signature: _____

Printed Name: _____ Phone numbers: _____

Person Authorized to pick-up child _____

PLEASE NO CAMERAS OR MONEY. THESE ITEMS ARE NOT NEEDED AT CAMP.

MEDICAL RELEASE

Camper's Name: _____

This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of Royal Family Kids' Camp or such substitute as they may designate as agent for the undersigned to consent to an x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medical Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is en route to and from or involved or participating in any camp activity, unless revoked in writing by the undersigned and delivered to the Director. The nurses have my permission to administer over-the-counter medicines such as: acetaminophen, cough syrup, and decongestant, throat lozenges, Pepto-Bismol, Tums, sunscreen, ibuprofen, insect repellent and Calamine lotion as needed. (You may draw a line through any medicine the minor may not take.)

Signature

Relationship

Date