

For Office Use Only	
_____	Received
_____	Chk. #
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Sponsored by:  
**Emmanuel Baptist Church**  
 2200 Eleventh Ave. Lewiston, ID 83501 208-305-3339 208-305-3226  
 June 17-21, 2019

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