

Dazzling Divas!

April 11th-13th 2008

Youth & Adult Registration & Health History Form (Please Print or Type)

Participant Information

Name: _____ Preferred Name: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Parent/Guardian's Name(s): _____

Home Phone: (____) _____ Other Phone: (____) _____ E-mail: _____

Birthdate: _____ Grade: _____ Church you attend: _____

Did you attend *Dazzling Divas!*, last year? _____ YES _____ NO (Please check one)

Emergency Contact: _____ Phone: _____ Relationship: _____

*Accompanying Adult: _____ (One female adult is requested to accompany every 6 youth from each local church, paying just \$20.00 to cover meal costs)

Insurance Information

Carrier or Plan Name: _____ Group #: _____

Carrier's Address: _____ Name of Insured: _____

Relationship to Camper: _____ Policy holder's social security # or insurance ID #: _____

Participant's Covenant

As a participant in *Dazzling Divas!*, I, the undersigned, will cooperate with the leaders of the camp. I will involve myself with camp activities offered. I will not bring any type of weapon(s), or use of any alcohol, tobacco, or drugs (except for prescribed medical purposes). I will behave as a Christian person.

Camper's signature: _____ Date: _____

Pastor Recommendation

 I support this camper's participation in *Dazzling Divas!*

Comments: _____

FOR PERSONS AGE 17 YEARS OR YOUNGER—I, the undersigned parent/guardian, give permission for the above named to participate in *Dazzling Divas!* I authorize use of photos/videos for future publicity. I hereby give permission to the camp to provide routine health care, including administration of non-prescription (over-the-counter medicines) as necessary in the judgment of the health care provider or designee, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. The following health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian: _____ Date: _____

FOR PERSONS AGE 18 YEARS OR OLDER—In signing this form, I hereby certify that the following health information is correct and complete as far as I know. 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 tests. In case of medical emergency, I understand that every effort will be made to contact the above named Emergency Contact person. In the event they cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization. I agree to the release of any records necessary for insurance purposes. I authorize use of photos/videos for future publicity.

Adult Signature _____ Date: _____

HEALTH INFORMATION

Participant's Name: _____

Allergies: List all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Describe reaction and management of the reaction.

ALLERGIES

REACTION AND MANAGEMENT

MEDICATION: Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Please 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. All medications must be checked in to camp staff upon arrival.**

NO Medications on a routine basis

Medication taken as follows: Attach additional pages for more medications, if necessary.

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking: _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking: _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking: _____

Identify any medications taken that the camper does not/may not take during this weekend: _____

SPECIAL NEEDS/RESTRICTIONS

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) and provide any information that will enable us to create a healthy, helpful environment for the camper. Please include: recent injuries of illnesses, medical conditions requiring treatment (i.e. surgery, overnight hospital stays, ongoing conditions, etc.), behavioral/learning challenges and suggested disciplines, emotional needs/concerns, hearing impairments, visual impairments, bedtime habits and any special routines.

Please list any **dietary** restrictions (other than allergies listed above) with explanation:

Name of Physician: _____ Phone: (____) _____

I examined this individual on _____. (A physical exam is recommended, but not required for retreat attendance.)

In my opinion, the above applicant is _____ (OR) is not _____ able to participate in an active camp program.

Comment: _____

Physician's signature: _____ Date: _____

Tetanus Current Date: _____

Immunizations Current Date: _____

After completing both sides of this Registration and Health History Form, please mail, along with your \$75 Early Registration Fee (\$95 if mailed after March 15th and \$20.00 for adults leaders), to Lazy F Camp and Retreat Center: 16170 Manastash Road, Ellensburg, WA, 98926. (Fax #: 509-962-2781). Questions?? Contact Lazy F (509-962-2780, office@lazyfcamp.org) or Megan Bondor (425-746-9800, youth_aumc@msn.com).