

Registration

This form must be completed by PARENT/ GUARDIAN. Please use one registration form per child. Copies may be made of this form.

CAMPER INFORMATION (where camper resides:)

Last Name _____ First Name _____ Initial _____

Mailing Address _____

City _____ State _____ Zip _____

Birth Date ____/____/____ Age ____ Grade completed June, 2012 _____ Male Female

Home Telephone _____

Camper E-mail _____

3 FOR FREE FRIEND: _____

CHURCH INFORMATION: Reformed Church in America Other _____

Church Name _____

Denomination _____

Address _____

City _____ State _____ Zip _____

Minister _____

Church Telephone _____

Church Email _____

CONSENT RELEASE

In signing this release, I certify that the information on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by The Warwick Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child/ward, as named herein. I understand that I am responsible for the cost of prescriptions, doctor visits and/or emergency room visits during my child/ward's stay at Camp Warwick. I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by my child/ward at on-site camps and supervise the First Aid Personnel of offsite camps in the distribution of medicines. I give permission for my child/ward to be transported in The Warwick Center vehicles or other designated vehicles to and from public transportation. I give permission for my child/ward to be transported in The Warwick Center vehicles as necessary for approved off-site camp activities. I authorize the use of photographs and videos of my child/ward in camp publicity.

Parent/Guardian Signature Date

NOTARY PUBLIC SIGNATURE

NOTARY PUBLIC STAMP

COUNTY & STATE
NOTARIZED HOSPITAL RELEASE STATEMENT REQUIRED BY THE MEDICAL FACILITY AND CAMP WARWICK.

Health Record

The HEALTH RECORD must be completed and signed by parent/ guardian and NOTARIZED before registration will be accepted.

Is this the camper's first summer at Camp Warwick? Yes No

Last Name _____ First Name _____ Initial _____

Birth Date ____/____/____ Age ____ Grade completed June 2012 _____ Male Female

PARENT/GUARDIAN INFORMATION (WHERE CAMPER RESIDES)

Mother's Last Name _____ First Name _____ Initial _____

Father's Last Name _____ First Name _____ Initial _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Father Cell Phone _____ Mother Cell Phone _____

Father Business Telephone _____ Mother Business Telephone _____

EMERGENCY CONTACT INFORMATION (IF PARENT/GUARDIAN CANNOT BE REACHED)

Emergency Contact _____ Telephone _____

Relationship to Camper _____

Family Physician _____ Telephone _____

Health Insurance Co. _____ Type of Policy _____ Policy # _____

Policy Holder Name and Address _____

Attach a photocopy of the insurance card (front and back).

Prescription drug policy? Yes No If yes, attach a photocopy of the prescription card (front and back).

PLEASE NOTE: The Warwick Center / Camp Warwick is not responsible

for the cost of prescriptions, doctor visits, or emergency room visits during camper's camp stay.

Is your child in general good health and able to participate in all normal camp activities? Yes No

Please check all boxes that apply to your child.

- | | |
|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Low/high blood pressure |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Severe menstrual cramps |
| <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Throat problems |
| <input type="checkbox"/> Homesickness | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Special needs | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Frequent nausea |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Jaundice/Hepatitis |
| <input type="checkbox"/> As infant | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Current problems | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Behavioral Issues |

FOR GIRLS: Has menstruated? Yes No

Been told about menstruation? Yes No

Please give specific information and current status regarding any of the boxes checked above.

FOOD ALLERGIES

List food(s) your child is allergic to: _____

What type of reaction does your child experience when ingesting these foods?

Hives Anaphylactic Shock GI Disturbance

What treatment is given?

None Benadryl Epi-pen (Requires a doctor's order. Complete Medical Authorization Form sent in confirmation packet.)

Is your child able to self-administer epi-pen? Yes No

Other: _____

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attending camp to discuss specific arrangements at 845-986-1164. Ask for Arlene Tenckinck.

SKIN ALLERGIES

Yes No If "yes", please list: _____

MEDICATION ALLERGIES

List any prescription or over-the-counter medications that your child is allergic to: _____

OTHER ALLERGIES

Bee Sting Poison Ivy/Oak/Sumac Hay Fever Suntan Lotion

Reaction: _____

Treatment: _____

IMMUNIZATIONS

This section must be completed IN FULL by parent/guardian in order for registration to be processed.

LIST DATES - NYS Requirement.

DPT _____ M.M.R. _____ Oral Polio Vaccine _____

Varicella _____ Hib _____

All immunizations are required unless a) it is medically contraindicated (doctor's signature required) or b) choose not to for religious reasons (documentation by religious leader necessary).

MEDICATIONS / CAMP WARWICK CAMPERS

List any medication (prescription and over-the-counter) that your child is currently taking: _____

I give permission to the Camp Warwick Health Director to supervise the self-medication of the following: (Check off)

Antacids / Tums Cold medications Tylenol Ibuprofen (Advil or Motrin)

Cough syrup/drops External ointments Suntan lotion Benadryl

Other over-the-counter medications (list): _____

Have you ever been hospitalized? Yes No

If yes, reason and date: _____

Chronic recurring illness _____

Any broken bones _____

Severe head, neck or back injury _____

Contagious diseases _____

Serious operations (list date/type) _____

Recent illness/injury _____

Please submit statement of how your child has been medically treated and with what medication.

The Camp Warwick Health Director will supervise the self-medication of prescription and over-the-counter medicines by campers at on-site camps and oversee the First Aid personnel of off-site camps in the distribution of medicine. All medications (prescription and over-the-counter) must be given to the Health Director at the time the camper checks in. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. All prescription medications must be in the original container, labeled with the camper's name, and written instructions signed by your physician must accompany the medication. All over-the-counter medications must be in the original container and labeled with the camper's name. A USE OF MEDICATION POLICY FORM will be mailed to the campers in the confirmation packet.

OVERNIGHT CAMPS

Please circle the weeks your child wishes to attend camp.

CAMP NAME	CAMP WEEK(S)	CAMP FEES
In Camp	2 3 W 4 5 6 7	\$ _____
Saddle Up Camp	2 3 4 5 6 7	\$ _____
Wilderness Camp	3 4 5 7	\$ _____
Amount church will contribute (check must accompany registration form)		\$ _____
	OVERNIGHT CAMP SUBTOTAL	\$ _____

BUNK PARTNER PREFERENCE (one name only): _____

DAY CAMPS

Please list below the weeks your child wishes to attend. FULL PAYMENT FOR THE FIRST WEEK your child wishes to attend must accompany registration. For each additional week your child wishes to attend, please remit a \$20.00 non-refundable deposit.

Please circle the weeks your child wishes to attend camp.

CAMP NAME	CAMP WEEK(S)	CAMP FEES
Kinder Kamp	1 2 3 4 5 6 7 8	First week fee: \$ _____
	Additional weeks deposit fee (_____ weeks @ \$20.00 per week):	\$ _____
Day Camp	1 2 3 4 5 6 7 8	First week fee: \$ _____
	Additional weeks deposit fee (_____ weeks @ \$20.00 per week):	\$ _____
Junior High Day Camp	1 2 3 4 5 6 7 8	First week fee: \$ _____
	Additional weeks deposit fee (_____ weeks @ \$20.00 per week):	\$ _____
	DAY CAMP / JHDC SUBTOTAL	\$ _____
	CAMP FEES GRAND TOTAL	\$ _____

PAYMENT OPTIONS ___ Check Enclosed. ___ Credit Card.

Please bill \$ _____ on my VISA or MASTERCARD (circle one)

Name as it appears on your credit card _____

Credit Card # _____ Exp. Date _____

Cardholder Signature _____



CAMP FEE MUST ACCOMPANY THIS

REGISTRATION, unless you are applying for a scholarship. Health forms must be filled out completely in order to hold your space. You will receive a confirmation mailing confirming the week(s) you are registered within four weeks after receipt of your registration.

SCHOLARSHIPS ARE AWARDED FOR OVERNIGHT CAMPS ONLY.

Scholarships are available through the generosity of the Synod of New York, Reformed Church in America; Reformed Church of Port Ewen Scholarship Fund; Jeremy P. Nulton Scholarship Fund; Rev. Herman D. DeJong Scholarship Fund and Joyce Weissert Memorial Scholarship Fund.