

Immunization Dates (Required)

Check which of the following diseases the camper has already had. <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatics	Vaccine For:	Dates	Dates	Dates	Dates
		Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
	Tetanus				
	Polio				
	MMR				
	Or Measles				
	Or Mumps				
Has the camper had a TB Mantoux Test? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last test: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Or Rubella				
	Hemophilus Influenza B				
	Hepatitis B				
	Varicella (Chicken Pox)				
Date of last physical exam. _____ <i>The camper must have had a physical exam no more than 2 years before the camp session for which they are registering.</i>					

General Questions (use additional sheet to explain "yes answers)

Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?.....	_____	_____
Have a chronic recurring illness/condition?.....	_____	_____
Ever been hospitalized?.....	_____	_____
Ever had surgery?.....	_____	_____
Have frequent headaches?.....	_____	_____
Wear glasses, contacts or positive eye wear?.....	_____	_____
Have a chronic, recurring illness/condition?.....	_____	_____
Have frequent headaches?.....	_____	_____
Have a history of bed-wetting?.....	_____	_____
Have problem with sleepwalking?.....	_____	_____
If female, have abnormal menstrual history?.....	_____	_____

Name of family physician _____

Office Phone (____) _____ Address _____

Name of family dentist/orthodontist _____

Office Phone (____) _____ Address _____

Use this to provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should be aware.

Do advance directives (living will, etc.) exist for this camper Yes No
 If yes, please send a copy with registration.

HEALTH HISTORY

Camper's Name _____

The following information must be filled out by the parent/guardian (when the camper is a minor), or adult camper or staff member. The intent is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health care personnel upon camper's arrival in camp. Provide complete information so that the camp can be aware of your needs.

LIST ALL KNOWN ALLERGIES AND DESCRIBE REACTION AND MANAGEMENT OF THE REACTION.

Allergies _____

Medication Allergies _____

Food Allergies _____

Other Allergies _____

LIST ALL MEDICATIONS TAKEN ROUTINELY

(INCLUDING OVER THE COUNTER OR PRESCRIPTION DRUGS) .

Be sure to bring enough medication for the duration of the camp session. All medications must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), name of the medication, the dosage and the frequency of administration.

Med #1 _____ Dosage _____ Times taken _____

Reason for taking _____

Med #2 _____ Dosage _____ Times taken _____

Reason for taking _____

Med #3 _____ Dosage _____ Times taken _____

Reason for taking _____

Attach additional pages for more medications. You MUST fill this out.)

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer: _____

Restrictions at camp (Please List) _____



2008 Camper Registration Form

Camper's Name _____
First Middle Last

Custodial Parent/Guardian _____

Home Address _____ City _____ St _____ Zip _____

Home Phone(____) _____ Work Phone (____) _____ Cell (____) _____

Parent E-Mail _____

Church Attending _____

Church Address _____
Street, PO Box City St Zip

Birth Date _____ Grade Completed _____ Age _____ Male Female (circle one)
Mo./Day/Yr.

School Camper Attends _____ School District _____

Camp Session Your Child plans to attend _____

Date of Camp _____ Camp: Tippecanoe Indian Creek (Circle one)

Name of person you desire to be housed with _____

T-Shirt Size (circle Size) Y-S Y-M Y-L A-S A-M A-L A-XL A-XXL A-XXXL

Camper Resident County _____

PLEASE READ AND FOLLOW ALL DIRECTIONS TO BE SURE YOUR CHILD WILL BE ADMITTED TO CAMP

Entire registration and medical form must be completed and signed in order to register for camp.

Balance due (line 6) must be received 14 days before beginning of camp session.

Line 1: **Camp session fee** (1) _____

Line 2: **Subtract discount that applies** (2) _____
 May 1, 2008 Postmark (\$10.00)

Line 3: **Family Discount** (First child no discount allowed) (3) _____
 Subtract \$10.00 for each additional registered camper from same family.

Line 4: **Subtotal** (results--line 1--3) (4) _____

Line 5: **Enter** amount paid with registration (5) _____
 (Min. \$25.00 non-refundable fee)

Line 6: **Subtract** line 5 from line 4 and enter the balance due if any (6) _____

Make checks payable to ABC/IN-KY and send forms to the camp you plan to attend.

Indian Creek Camp
 1770 Avoca Eureka Rd.
 Bedford, IN 47421
 Ph. (812)279-2161
 Fax (812)279-6620
 icregistration@insightbb.com

Tippecanoe Camp
 PO Box 23
 North Webster, IN 46555
 Ph. (574)834-4184
 Fax (574)834-1907
 tippyreg@embarqmail.com

Limited scholarships are available. Contact the camp you plan to attend for more information.

Camper Medical Form

Camper's Name _____
First Middle Last

Camper Social Security Number _____

2nd Parent/Guardian or Emergency Contact _____

Home Phone(____) _____ Work Phone (____) _____ Cell (____) _____
 If not available in an emergency, notify

Name _____

Relationship _____ Home phone (____) _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE (Please read carefully.) Your signature below means that you give this permission:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment: to release any records necessary for insurance purposes: and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the camper named above. I also give permission to the camp medical staff selected by the camp director to review the medical information enclosed in this document. This complete form may be photo copied for trips outside of camp grounds.

INSURANCE INFORMATION (Your child will not be admitted to camp without this information.)

Is the camper covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group No. _____

Name of insured _____ Relationship to camper _____

YOU MUST SIGN THIS FORM IN THE BOX TO THE RIGHT. BY SIGNING YOU ARE STATING THE FOLLOWING:

PARENT/GUARDIAN SIGNATURE REQUIRED:

(Your child will *not* be admitted to camp without your signature)

PARENT/GUARDIAN SIGNATURE

PARENT/GUARDIAN SIGNATURE PRINTED

WITNESS SIGNATURE

The health history is correct and complete as far as I know. The camper named above has permission to engage in all camp activities except as noted elsewhere on this form.

I give my permission for photographs to be taken during the camp experience to be used for promotional purposes. Yes No

FOR OFFICE USE ONLY:

Date Reg. Rec'd _____ CK No. _____ Amount _____ PT. ____ CH ____

2nd Ck Rec'd _____ CK No. _____ Amount _____ PT. ____ CH ____

PARENTS OR GUARDIAN: PLEASE PRINT OR TYPE ALL INFORMATION CLEARLY. FILL OUT THE ENTIRE FORM.