

IMPACT 2818 OUTDOOR MINISTRIES

SPECIAL SKILLS CAMP & CAMP REYOAD REGISTRATION FORM

Guardian and Prospective Campers: Please read this application carefully and FILL IN ALL BLANKS! Campers will NOT be enrolled if necessary information is withheld.

Sponsorship: Camp REYOAD and Special Skills Camp are sponsored by the Indiana Conference of the United Methodist Church, but enjoys ecumenical participation and leadership.

Insurance: All campers are provided with limited accident insurance while at camp.

Medication: All medications WILL BE secured and dispensed by the staff. All medications are to be in the original container and WELL-LABELED.

Registration Deadline & Fees: Registration deadline is May 15, 2010. Impact 2818 Outdoor Ministries programs offer early bird registration discounts. The base price of camp is listed in the brochure and on our website. If registering after the third Monday of April (April 19, 2010) add \$20 to the base price of camp. REYOAD campers are also asked to bring to camp an additional activity fee of \$30.

Scholarships: Scholarships are available for all campers. You may apply online or download a paper application form from our website, www.beacamper.com.

CRITERIA OF ACCEPTANCE

- Camp REYOAD campers must be 16-65 years of age.
- Special Skills Camp campers must be 12-18 years of age.
- Physically and mentally capable of participating in the program.
- Free from psychiatric and psychological problems.
- Socially capable to adjust to group living.
- Able to eat cafeteria food (NO SPECIAL DIETS).
- Nonsmoking: smoking is not permitted on the campgrounds.
- REYOAD ONLY:
- MUST be independently ambulatory (much walking is done).
- MUST be capable of self-care (TOILET-TRAINED, personal cleanliness, self-dressing and FREE FROM BEDWETTING!!!)

MAIL all completed forms and payment to:
Impact 2818 Outdoor Ministries Registrar
301 Pennsylvania Park Way
Suite 300
Indianapolis, IN 46280

CAMPER INFORMATION
You must respond to all blanks.

Please Include a Recent Photo

Name of Camper _____

Nickname of Camper _____

Camper Address _____

City, State _____ Zip _____

Telephone (____) _____

Date of birth _____
Month Day Year

Social Security # _____

Medicaid/Medicare _____

Church Name _____

Church City and State _____

T-shirt size (circle one) - Small Medium Large XL XXL XXXL

Name of Guardian _____

Guardian Address _____

Phone 1 (____) _____ (W-H-C) Phone 2 (____) _____ (W-H-C)

Other Emergency Contact Name _____

Relationship _____ Phone (____) _____

On the back, please include a brief family history related to your camper.

MEDICAL INFORMATION AND CONSENT FORM

CAMPER MUST HAVE BEEN SEEN BY A DOCTOR RECENTLY

Name of Camper _____ Date _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Identified Disability _____

Physician's Name _____ Phone _____

Physician's Address _____

KNOWN MEDICAL CONDITIONS:

Allergies Y/N (list)

(plants, prescription and non-prescription drugs, insects, food, etc.)

Seizures Y/N

frequency _____

Other (list)

HEALTH HISTORY:

Please circle all that apply:

Heart Weakness Asthma Fainting Chronic Respiratory Infection

Menstrual Problems Constipation Athlete's Foot Stomach Upsets

Sleepwalking Bedwetting Homesickness Emotional Upsets

Please circle all that apply:

Verbal Non-Verbal Uses Signing Non-Verbal but Understands

Writes Hears Fine Uses Hearing Aid Is Deaf

Walks Alone With Assist With Walker Wheel Chair Dependent

With Cane Wears Braces Weight Bearing Non Weight Bearing

Wears Glasses Wears Dentures

Immunization Dates: Last Tetanus _____ Last TB Test _____

Hepatitis Status: Screening Date _____ Vaccination Date _____

LEVEL OF SELF CARE:

Dressing/Undressing: Self Assist Toilet Needs: Self Assist

Shower Needs: Self Assist Diet: Self Assist

Are there any foods or activities that the camper should avoid?

Does camper have any special fears or concerns?

Any other information about the camper that might be helpful:

MEDICATIONS:

(List all prescription and non-prescription medications to be used during camp):

MEDICATION NAME	DOSAGE	TIME TO BE GIVEN	OTHER INFORMATION
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1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

All medications will be kept with and dispensed by the camp nurse.

Each medication must be in its own prescription labeled bottle or package. All non-prescription items must be in their original packages or containers and labeled with the camper's name. NO EXCEPTIONS!

Medical Treatment Release

I authorize the Director (or his/her designee) to seek emergency medical treatment necessary to maintain the health and safety of the camper named hereon. ***We agree to come pick up the camper, if necessary.***

SIGNATURE OF PARENT/GUARDIAN

Is Camper Emancipated with No Guardian? Yes ___ No ___

Date of Signature ____/____/____

Name of Insurance Company _____

ACTIVITIES INFORMATION FORM

TO PARENT/GUARDIAN: Take this form to your camper's school or workshop to have completed. Include it with all forms to be sent to the Camp Registrar.

TO WORKSHOP OR ACTIVITIES DIRECTOR: Please be thoughtful and candid.

Name of Camper _____ Age _____

Name of workshop or activity _____

Address of above _____

Name of contact person _____ Phone(____) _____

How well or poorly does applicant participate in group activities? _____

Any additional comments (i.e. How does applicant get along with others? List the applicant's hobbies, interests, unusual behavior and fears).

Date _____

Signature of Principal, Director or Adult in Charge