**FIRST PRESBYTERIAN DAY CAMP REGISTRATION FOR PRE-KINDERGARTEN AND KINDERGARTEN**

(Complete a form for each child)

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian/Parent’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Emergency Contacts/phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to Contact Primary Care YES NO

Health Insurance – Policy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN or Insurance ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holders Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Carrier Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health - CHECK ALL THAT APPLY:

* Asthma
* Diabetes
* Anorexia, Bulimia
* Glasses, Contacts or protective eyewear
* Mono (in last 12 mo.)
* Back Problems
* Heart Murmur
* Joint problems
* Orthodontic Appliance Required at Day Camp
* Bleeding, Clotting
* High Blood Pressure
* Seizures, Convulsions
* Knocked Unconscious
* Skin Problems (itching, rash)
* Chest pain, Dizzy, Passing Out
* Immunodeficiency
* Lice
* Short of Breath, Wheezing
* Sleepwalking

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurring Health Issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations and Serious Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health Issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last travel outside of the United States \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health – CHECK ALL THAT APPLY:

* Attention Deficit Disorder (ADD or AD/HD)
* Depression
* Disordered Eating
* Learning or Processing Challenge (disability)
* Obsessive-Compulsive Disorder
* Panic, Anxiety Disorder
* Substance Abuse
* Other Mental, Emotional, or Social Health Issue

Nutrition – CHECK ALL THAT APPLY:

* No Dairy
* No Eggs
* No Wheat
* Vegan
* Vegetarian

Prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Over the Counter Medicines – CHECK ALL THAT APPLY:

* Acetaminophen (Tylenol)
* Antidiarrheal (Maalox)
* Bismuth Subsalicylate (Pepto Bismol)
* Calamine Lotion
* Cough Drops
* Diphenhydramine (Benadryl)
* Ibuprofen (Advil)
* Loratadine (Claritin)
* Poison Ivy Treatment (Ivy Dry)

TERMS & CONDITIONS:

*In signing this application and health form, I hereby certify that the above information is correct and give permission for the release of medical records in case of illness or accident.*

*In case of medical emergency, I understand that every effort will be made to contact a parent or guardian of the day camper. In the event I cannot be reached, I hereby give permission to the physician selected by First Presbyterian Church to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the participant named above.*

*I give my child permission to participate in all camp activities, appropriate to my child’s age. I understand that First Presbyterian trains the staff and inspects their equipment to reduce risk. I understand there are still inherent risks with all camp activities. I release First Presbyterian and all its employees from any liability related to my child’s participation in camp activities, which may include bending, twisting, lifting, running, jumping, climbing, increased heart or breath rates and physical contact with others. Unexpected strains or jolts to my child’s body can occur.*

*I agree to allow my child (or myself) to have his/her picture taken and those pictures to be used in First Presbyterian publicity. My child agrees to follow all camp rules and expectations. I will arrange transportation home at any time for my child if First Presbyterian Church requires it due to behavior or illness.*

*The undersigned understands that each participant must assume the risk of injury that could result from any of these activities. The undersigned releases First Presbyterian Church, its employees, agents, and representatives, volunteers and officers from any and all liability, claims or causes of action for loss of or damage to property or to any injury to the participant arising from participation in Day Camp activities.*

**By my signature, I affirm that this health history is correct and complete to the best of my knowledge and that I have read, understood and agree to the Terms and Conditions specified in this form.**

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Signature Date