

# Summer Camp 2010



*Every year for the past 20 years the Jr. High ministry has provided a summer camp for our students. We anticipate over 300 students attending our three summer camps. God continues to use summer camp to change students' life. We are praying this year will be no different.*

*With daily Bible teachings and morning quiet time students are exposed to the bible, prayer and fellowship. This year our topic is the life of Joseph. During the day students have opportunities to swim, play sports, participate in arts and crafts, and much more. Students spend their camp with students from their Friday night cell groups. If students are not in a cell group they will be placed with their friends.*

*We run our camp at Camp Ohio, located in Saint Louisville, Ohio (about 1 hour northeast of Columbus). They provide excellent food service and naturalist for some of our activities. All cabin counselors and the camp nurse are volunteers in the Jr. High ministry at Xenos Christian Fellowship.*

*Please call or e-mail with any questions or clarifications. Sarah Parrott will be handling registration. You can contact Sarah at 614.823.6510 ext. 121 or parrotts@xenos.org.*

*Travis Henderson  
Blow Out Director*



## **General Information**

Parents will drop off & pick up students at Camp Ohio  
**Drop off will be from 1.30pm - 2.30 pm and pick up will be at 10am**

We provide free nightly snacks but there will be a pay snack bar available most evenings.

Find all current information on the website:

**[www.xenos.org/summercamp](http://www.xenos.org/summercamp)**

# Camper Registration

## 1. Camper Information

Camper Name:	
Parent names:	
Home address:	
City:	Zip:
Phone:	Cell:
Parent Email:	
Emergency phone:	
Birthdate:	
Grade starting in Sept. 2010:	

## 2. Cell group

Camper's cell group:
*school district if starting 6 <sup>th</sup> grade
*cabins are assigned by cell group

## 3. Communication

Do you prefer further communication by: <input type="checkbox"/> Email <u>or</u> <input type="checkbox"/> Postal Mail We are using email as much as possible to save on administrative costs.
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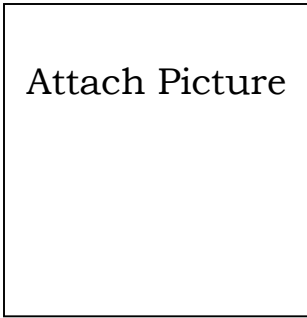
## 4. Payment Information

Circle the grade the camper will attend Fall 2010:		
6 <sup>th</sup> grade July 29 <sup>th</sup> – Aug. 1 <sup>st</sup> \$160	7 <sup>th</sup> grade Aug. 1 <sup>st</sup> - 5 <sup>th</sup> \$210	8 <sup>th</sup> grade Aug. 5 <sup>th</sup> -9 <sup>th</sup> \$220
<ul style="list-style-type: none"> <li>• <b>Completed</b> registration (including immunizations) with a \$25 non-refundable deposit is due by July 11<sup>th</sup>.</li> <li>• Remaining balance will be due by July 26<sup>th</sup>.</li> <li>• Registrations received by June 13<sup>th</sup> will be entered into a drawing for free camp. Two registrations will be randomly picked.</li> <li>• Families with more than one Jr. High student attending: The first student is full rate, but each additional child will have a \$25 discount</li> <li>• All checks should be made out to: Xenos Christian Fellowship</li> <li>• Send forms to: Sarah Parrott 1340 Community Park Dr. Columbus, OH 43229</li> <li>• We would be willing to help families in need cover camp expenses. <input type="checkbox"/></li> </ul>		

## 5. Permission/Liability/Medical Release

<p>I give permission for my son/daughter, listed above to participate in the Jr. High Summer Camp. Most adult chaperones are volunteers (not on Church staff) from Xenos Christian Fellowship.</p> <p>I understand that in spite of the best and focused efforts of these volunteer adult chaperones to provide a safe and healthy environment for my child, circumstances may arise leading to unintentional injury of losses on the part of our child. I release Xenos Christian Fellowship and their agents from all claims and expenses arising out of, or resulting from, my child's participation during this event.</p> <p>I give permission for any medical personnel to render necessary emergency medical care for my child if I can't be reached or if my child needs immediate medical attention.</p>	
Signature of parent or guardian	date
Printed name of parent or guardian	

# 4-H Camp Ohio Participant/Member Health History



This form must be completed for each participant. Minors must have the form completed and signed by parents/guardians. This information will be kept confidential and used only for the welfare of the participant.

Date: \_\_\_\_\_ County: \_\_\_\_\_  
 Please Circle: Male/Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Name:** \_\_\_\_\_  
 (Last) (First) (Middle)

Address: \_\_\_\_\_  
 (Street) (City) (State) (zip)

Phone: (Home) \_\_\_\_\_ Guardian's Work Phone: \_\_\_\_\_

**In Case of Emergency Contact:**

Parent Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Other Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Health History

**LIST APPROXIMATE DATE IF PARTICIPANT HAS HAD OR BEEN EXPOSED TO:**

Chicken Pox \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Whooping Cough \_\_\_\_\_  
 Any Communicable Diseases \_\_\_\_\_ Date of Last Menstrual Period \_\_\_\_\_

**CHECK BELOW IF PARTICIPANT IS SUBJECT TO:**

Headaches \_\_\_\_ Fainting \_\_\_\_ Heart Trouble \_\_\_\_ Frequent Colds \_\_\_\_ Constipation \_\_\_\_ Convulsions \_\_\_\_  
 Frequent Sore Throats \_\_\_\_ kidney Trouble \_\_\_\_ Athlete's Foot \_\_\_\_ Sinusitis \_\_\_\_ Sleep Walking \_\_\_\_ Ear  
 infections \_\_\_\_ Epileptic Seizures \_\_\_\_ Home Sickness \_\_\_\_ Bronchitis \_\_\_\_ Cramps \_\_\_\_  
 Asthma Controlled (Yes/No) \_\_\_\_ Other (please specify) \_\_\_\_\_

**LIST OTHER PRESENT MEDICAL CONDITIONS** or special needs that require medications, treatments or special restrictions or considerations in participation \_\_\_\_\_

**LIST ANY PAST MEDICAL TREATMENT, IF ANY:** \_\_\_\_\_

**IMMUNIZATION RECORD:** Please record the year of basic immunizations and most recent booster date.

Vaccines	Year of Basic Immunization	Year of Basic Immunization
Hepatitis B (hepB)		Varicella
Diphtheria, Tetanus, Pertussis (DTaP)		Meningococcal (MCV4)
Haemophilus influenzae type b (HIB)		Pneumococcal (PCV)
Inactivated Poliovirus (IPV)		Influenza
Measles, Mumps, Rubella (MMR)		Hepatitis A (HepA)

Tetanus (Date of last tetanus shot) \_\_\_\_\_

*All educational programs and activities conducted by Ohio State University Extension are available to all potential clientele on a nondiscriminatory basis without regards to race, color, creed, religion, sexual orientation, national origin, sex, age, handicap, or Vietnam-era veteran status.*

(Please See Other Side)

## INSTRUCTIONS FOR MEDICATIONS

1. All prescription drugs **MUST** be carried in the container in which they were issued (with medical orders and physician's name intact) and given to the nurse/health director. Others will not be accepted.
2. If you need over-the-counter medications not listed below, they must be in the original container and must be stored under lock and key by the nurse/health director.

### ALLERGIES (please print)

Food Allergies: \_\_\_\_\_  
Medication Allergies: \_\_\_\_\_  
Serious Ivy, Oak, or Sumac Poisoning: \_\_\_\_\_ Bee or Insect Stings: \_\_\_\_\_  
Prescribed Treatment: \_\_\_\_\_

### CHECK MEDICATIONS BELOW THAT PARTICIPANT MAY RECEIVE IF NECESSARY:

Acetaminophen \_\_\_\_\_ Benadryl \_\_\_\_\_ Caladryl \_\_\_\_\_ Calamine \_\_\_\_\_ Chloraseptic \_\_\_\_\_ Claritin \_\_\_\_\_ Epi-Pen \_\_\_\_\_  
Ibuprofen \_\_\_\_\_ Immodium \_\_\_\_\_ Insect Repellent \_\_\_\_\_ Maalox \_\_\_\_\_ Milk of Magnesia \_\_\_\_\_ Neosporin Ointment \_\_\_\_\_  
Robitussin DM \_\_\_\_\_ Silvadene Cream \_\_\_\_\_ Sudafed \_\_\_\_\_ Sunscreen \_\_\_\_\_

### MEDICATIONS (Currently taking )

Name	Dosage	Frequency

## PARENT/GUARDIAN MEDICAL RELEASE

### Part I (To Grant Consent)

We will notify you if our health care provider thinks your child should go to the doctor or emergency room.

\_\_\_\_\_ in the event reasonable attempts to contact have been unsuccessful, **I hereby give my consent for:** (1) the administration of any treatment deemed necessary by preferred physician and preferred dentist, listed on the front of this form, or in the event the designated practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to appropriate hospital or urgent care center reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

### Part II (Do not complete Part II if you completed Part I)

\_\_\_\_\_ **I do not give consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish 4-H Camp Ohio and the sponsoring agency authorities to take no action or to \_\_\_\_\_

### Part III

\_\_\_\_\_ has my permission to participate in the Ohio 4-H program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand the 4-H staff and volunteers, Ohio State University Extension and The Ohio State University are not responsible in the event of accidental injury or illness, nor for the compounded injury or illness to the participant's present medical conditions listed. I further understand in case of serious injury or illness I will be notified.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PHOTO/VIDEO RELEASE

I give permission to The Ohio State University, OSU Extension, the Ohio 4-H program and 4-H Camp Ohio to use photographs, voice and video images of the participant named above and photographs, voice and video images of any activities in which the participant is involved in any and all public awareness programs of The Ohio State University, OSU Extension, the Ohio 4-H program and 4-H Camp Ohio.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**4-H Camp Ohio  
Adventure Program Permission Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Emergency Medical Information**

(If "Yes", please explain on the lines following the question.)

No \_\_\_\_\_ YES \_\_\_\_\_ Allergies to foods, drugs, insect bites, dust, etc. Please identify them and the nature of your reaction.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO \_\_\_\_\_ YES \_\_\_\_\_ Physical disabilities or conditions which might limit your participation:

\_\_\_\_\_  
\_\_\_\_\_

NO \_\_\_\_\_ YES \_\_\_\_\_ If you are presently taking medication(s), please identify them:

\_\_\_\_\_  
\_\_\_\_\_

**In Case of Emergency, Contact:**

Name	Relationship	Home Phone	Work Phone
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**Statement of Understanding**

I am aware in signing this statement for participation in programs of 4-H Camp Ohio that certain activities are physically demanding. Therefore, physical fitness will increase the enjoyment and ability to participate in the activity. If for any reason I question the ability of the participant to participate in the activity, I will consult with the instructors prior to participation. While it is impossible to foresee all possible dangers, some of the specific hazards which might be encountered while participating in adventure programs include: slipping or falling on the trail, bumps, bruises, cuts, insect bites, poison ivy, sprains, fractures or other injuries. I understand that most activities are conducted in the out-of-doors in all kinds of weather, so proper dress (rain gear, warm clothing) are essential to avoid undue exposure to known risks; however, as a participant, I acknowledge the nature of the activity and the fact that not all of the stresses and hazards connected with the activity can be foreseen. I have the personal responsibility to follow the established safety rules and procedures to the extent that I participate in such activities. If at any time I have questions about the activity, I have the responsibility to consult with my instructor. Sponsoring agencies have the responsibility of providing a progression of appropriate activities which lead to the experiences at 4-H Camp Ohio.

I recognize that there is a significant element of risk in any adventure, sport or activity associated with the outdoors. Knowing the inherent risks, dangers and rigors involved in the activities, I certify that the participant (including any minor children) is fully capable of participating in the activities.

I assume full responsibility for the participant (including minor children), for bodily injury, death, loss of personal property and expenses thereof, as a result of my negligence or the negligence of the participant.

Signature	Date
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(Parent or legal guardian must sign for all persons under 18 years of age.)

Note: All participants should wear long pants (no shorts) and tennis shoes on the high ropes course.

# Emergency Medical Authorization for Participants Under 18 Years of Age

Child's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under 4-H Camp Ohio and sponsoring agency authority, when parents or guardians cannot be reached.

## Part I or II – Must be Completed

### Part I (To Grant Consent)

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone#) or \_\_\_\_\_ (other parent/guardian) at \_\_\_\_\_ (phone#) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (Preferred physician) at \_\_\_\_\_ (phone#) or Dr. \_\_\_\_\_ (Preferred dentist) at \_\_\_\_\_ (phone#) or in the event the designated practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature

Date

Address: \_\_\_\_\_

### Part II (Do not complete Part II if you completed Part I)

I **do not** give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish 4-H Camp Ohio and the sponsoring agency authorities to take no action or to

\_\_\_\_\_  
\_\_\_\_\_

Signature

Date

Address: \_\_\_\_\_