

Camper Information

\$130 for first camper, \$110 for each additional camper

Name _____

Address _____

__ Male __ Female Date of Birth _____ Church Registered _____

Parent/Guardian Name _____

Address _____

Best Contact Phone #: _____ email: _____

In case of emergency, alternative contact info: _____

Transportation Release

I give permission for (name) _____ to transport my child from Adirondack Baptist Association Camp at the close of camp. Photo ID may be requested from this individual at the request of camp staff.

Release for Temporary Leave

I give permission for my child to leave camp for (activity) _____ on (date) _____ at (time) _____ . He/she will be returning at (time) _____ . (Name) _____ will be transporting him/her. Photo ID may be requested from this individual at the request of camp staff.

Family Health Insurance Information

Name of company: _____

Telephone Number: _____ Contact Person: _____

Name on Policy: _____ Policy/Group Number: _____

Include a copy of your shot records. (Your local school will have this on file if you do not have a copy.)

- ABA Camp participants who participate and/or engage in related activities waive and release ABAC from any claim for personal injury or property damage. Attendees agree to carry insurance and/or cover such.
- I give permission for sunscreen and bug spray to be administered to my child as needed.
- I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests, and treatment for me/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 hospitalize, secure proper treatment for, and to order injection and/anesthesia and/or surgery for me/my child as named above.
- I understand that during the course of my child’s stay at camp, they may be photographed or videotaped and may be used in future camp promotional materials and/or posted on the camp website.

❖ Signature of parent/guardian _____ Date _____

❖ Checkout Signature: To be signed when leaving camp _____
Date _____

Camper's Name: _____

Parents or Guardians, please fill out the appropriate information for your child.

Approval /Disapproval of Administration of Medication

The following may be administered to your child, if needed, while at camp. Your physician's signature and approval is required. Indicate approval/disapproval if administered by camp medical personnel as needed.

Medication Name	LHCP Order	Comments
Acetaminophen	Yes No	
Ibuprofen	Yes No	
Diphenhydramine HCl	Yes No	
Guaifenesin usp	Yes No	

Allergies

Please list any allergies the camper has. This includes medication and food allergies.

Allergy	Symptom	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food allergy

- Peanuts Milk Nuts Fish
- Soy Wheat (gluten) Eggs Tree nuts
- Other _____ YOU MUST CONTACT DIANNA BOGART ASAP at campcook@threebhut.com.

Camper's Current Medication Regimen

List current medications and over the counter medications to administer during camp. Include vitamins, herbs and supplements. Your physician's signature is required for the camp nurse to administer medications to your child.

Medication Name	Route	Dosage	Frequency (circle all that apply)			
_____	_____	_____	Morning	Afternoon	Evening	Bedtime
_____	_____	_____	Morning	Afternoon	Evening	Bedtime
_____	_____	_____	Morning	Afternoon	Evening	Bedtime
_____	_____	_____	Morning	Afternoon	Evening	Bedtime

Camper's Current Medication Regimen

- ❖ Signature of Licensed /Certified Health Care Provider _____ Title _____
- ❖ Phone Number _____ Date _____

PATIENT CONSENT FORM

Parents or Guardians, please fill out the appropriate information for your child.

ATTENTION: Parents/Legal Guardians Did you know that if your child has an accident or illness in your absence-except in the case of injuries which threaten life or limb- patients under the age of 18 years old must have a parent or legal guardian sign a consent form before treatment can be given in an emergency room? You can save time and the concern of the person to whom you entrust the care of your child should this be necessary during your absence. It is important to include any allergy, illness history and medications that your child is taking as well as the name of the child's physician and last tetanus immunization.

Complete this form to be used if needed:

Patient Consent Form

Camper's Full Name (patient) _____ Age _____
Home Address _____ Date of Birth _____
Phone _____ Cell Phone _____
Name of (parent/guardian) _____
Employer _____ Health Insurance # _____
Health Insurance Carrier _____
Guarantor (person carrying insurance) _____
Family Medical Doctor _____ Phone _____
Address _____
Current Medications _____
Allergies to Medications _____
Pertinent Medical History _____

In the event that your efforts to reach me are unsuccessful, I, parent or legal guardian, consent to Emergency evaluation, treatment and/or admission to Alice Hyde Medical Center as determined by the physician in charge of the care of the above named person.

❖ Signature _____ (parent/guardian)
Date _____