

# PRAIRIE STATES CHRISTIAN SERVICE CAMP

P. O. Box 363 \* Watseka, IL 60970 \* 815/432-3578

## Registration Card

(may be downloaded, printed and used for registration purposes)

Name of Camp Week \_\_\_\_\_ Date of Camp Week \_\_\_\_\_

Camper's Name \_\_\_\_\_ Attended Before? Yes  No

Mailing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Church Attended \_\_\_\_\_

Male  Female  Has Camper been Baptized by immersion? Yes  No

*To ensure the health and safety of our campers, the faculty may need to search luggage for weapons, drugs or alcoholic beverages. Your signature on this form will give permission to inspect your camper's luggage, if necessary.*

I have read and fully understand the camp rules. If the camper fails to abide by these guidelines, disciplinary action will result.

Parent or guardian \_\_\_\_\_ *signature* \_\_\_\_\_ Date \_\_\_\_\_

Camper's signature \_\_\_\_\_ *signature* \_\_\_\_\_ Date \_\_\_\_\_

### *For office use only*

Pre-registration \_\_\_\_\_ Balance \_\_\_\_\_ Church Contribution \_\_\_\_\_

Canteen \_\_\_\_\_ Mission \_\_\_\_\_ T-Shirt \_\_\_\_\_ Donation \_\_\_\_\_

## MEDICATION PERMISSION FORM

I, the parent or guardian of the camper named on this form, give my permission for the personnel at PSCSC to:

1. Dispense Tylenol or Advil to camper for headache, fever or minor pains;
2. Dispense Benadryl to camper for allergic reactions;
3. Dispense Tums or Kaopectate to camper for upset stomach;
4. Dispense Hydrocortisone Cream or other antibiotic ointment to camper for minor cuts or scrapes;
5. Dispense prescription or over-the-counter medication designated by and provided by the parent/guardian or family physician.

Parent/Guardian Signature \_\_\_\_\_ *signature* \_\_\_\_\_ Date \_\_\_\_\_

### **Instructions for Administering Medications Provided by Family**

Medication Name \_\_\_\_\_ Taken for \_\_\_\_\_

Possible Reaction \_\_\_\_\_ Dosage/Times \_\_\_\_\_

Medication Name \_\_\_\_\_ Taken for \_\_\_\_\_

Possible Reaction \_\_\_\_\_ Dosage/Times \_\_\_\_\_

**ALL MEDICINES MUST BE TURNED IN AT CHECK-IN IN THE ORIGINAL CONTAINER!**

# MEDICAL RELEASE

(may be downloaded, printed and used for registration purposes)

Camper Name \_\_\_\_\_ Camper Week \_\_\_\_\_

Emergency Contacts:

Contact Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Telephone Nos. (home) \_\_\_\_\_ (Work) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name under whom camper is insured \_\_\_\_\_

The camp insurance plan, underwritten by Brotherhood Mutual, provides "second pay" coverage after the first \$500 on any medical claim. They will pay the first \$500 for your child. The claim will then be turned over to your insurance company for payment. Brotherhood Mutual will pay the balance, including your deductible, up to \$5,000 total. If you have questions, check the printed example at the registration window at the camp.

I understand that, in the event of an emergency, PSCSC will make every effort to contact those people listed on this form. In the event that PSCSC is unable to contact me or the designated emergency contact, I give permission to the physician selected by the camp management to secure treatment for my child as named on this form.

I understand that completion of this medical form with my signature grants the above-named camper permission to participate in the PSCSC program. I release PSCSC staff, faculty, officers and management from any liability and will not hold them responsible for any articles lost, stolen or left at the camp. PSCSC has my permission to use any video or photos taken of my child while attending or participating in a camp program, for the purpose of promoting PSCSC and its ministry.

Parent/Guardian Signature \_\_\_\_\_ *signature* \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL HISTORY

**Health History** (Please give approximate dates)

Allergies	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Poison Ivy, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>

Allergies: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Date of last Tetanus booster: \_\_\_\_\_

Other important info: attach extra page

Various Medical Conditions:

Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Head Lice	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Fears/Phobias	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>