LINCOLN PRESBYTERIAN HIGH SCHOOL RETREAT JULY 26-28, 2019

REGISTRATION FORM

Camper Name _____ ❑ Male ❑ Female

Birthday _____ Grade in Fall 2019: _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian 1 _____ Relationship _____

Primary Phone _____ Secondary Phone _____

E-mail _____

Parent/Guardian 2 _____ Relationship _____

Primary Phone _____ Secondary Phone _____

E-mail _____

Cabin Mate Request: _____

$100 per person (Incoming Sophomore-College Freshman) **Incoming Freshman: $40** **Payment due one week before Retreat**

Payment Options: □Mexico Bundle □Cash □ Check (Please make check out to LPC) □Credit Card

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Health Information

The health and safety of each camper is important to us. This essential information allows us to best care for your camper. All information provided will be kept confidential. **Please attach a note with any additional health concerns.** Please notify camp if your child is exposed to any communicable disease during the two weeks prior to camp attendance. For campers with **asthma**, a rescue inhaler must be kept with them at all times. For life threatening **allergies**, please provide epi-pen. All prescription and non-prescription **medications** must be turned into the camp nurse at check-in. Prescription medications must be in the **original prescription package** and clearly labeled with the camper's name and dosage by the pharmacy. Non-prescription medications, including vitamins, must be in their original packaging and be labeled with the camper's name. P**ill boxes will NOT be accepted.**

EMERGENCY CONTACT: *Please provide emergency contacts in the event that parents/guardians cannot be reached.*
Emergency Contact #1 Name _____ Relationship _____
Primary Phone _____ Secondary Phone _____
Emergency Contact #1 Name _____ Relationship _____
Primary Phone _____ Secondary Phone _____

BASIC INFORMATION: Camper Height _____ Weight _____

IMMUNIZATIONS/TETANUS: Are all immunizations up to date? Y ❑ N ❑ Date of last Tetanus/Tdap ___/___/___

ALLERGIES: Y ❑ N ❑ *For life threatening allergies, please provide epi-pen.*

Name of allergen _____ Type (circle): Food / Drug / Other
Describe reaction and severity
_____
_____

Name of allergen _____ Type (circle): Food / Drug / Other
Describe reaction and severity
_____
_____

DIETARY NEEDS: Y ❑ N ❑ *We are able accommodate most vegetarian, vegan, gluten-free, and dairy-free diets.*
If yes, explain: _____

MEDICAL CONCERNS/ACTIVITY RESTRICTIONS: Y ❑ N ❑ If yes, explain: _____
_____

INSURANCE INFORMATION: Is the camper covered by family medical/hospital insurance? Y ❑ N ❑
Insurance Company Name _____ Phone _____
Group Number _____ Policy Number _____
Subscriber's Name _____ Subscriber's DOB _____

MEDICATIONS: Will the camper be taking prescription and/or non-prescription medication while at camp? Y ❑ N ❑ ***Review camp instructions about required packaging found at the top of this page. Attach a separate sheet to list more medications.***

Medication #1 Name _____ Dosage _____
Reason for taking _____
How is medication given (e.g. orally) _____ Start Date _____ End Date _____
When is medication delivered? (e.g. breakfast, bedtime, as needed) _____

Medication #2 Name _____ Dosage _____
Reason for taking _____
How is medication given (e.g. orally) _____ Start Date _____ End Date _____
When is medication delivered? (e.g. breakfast, bedtime, as needed) _____

Medication #3 Name _____ Dosage _____
Reason for taking _____
How is medication given (e.g. orally) _____ Start Date _____ End Date _____
When is medication delivered? (e.g. breakfast, bedtime, as needed) _____

Forbidden over-the-counter Medications: The following non-prescription medications may be stocked with the Health Assistant and are used on an as needed basis to manage illness and injury. Check those medications that camper should **NOT** be given.

❑ Acetaminophen (Tylenol) ❑ Antibiotic Cream ❑ Antihistamine/allergy medication ❑ Ibuprofen (Advil, Motrin)

GENERAL HEALTH HISTORY: Check "Yes" or "No" for each statement. Explain "Yes" answers below. Attach a separate sheet if necessary.

Ever been hospitalized?	Y ☐ N ☐	Ever had surgery?	Y ☐ N ☐
Have recurrent/chronic illness?	Y ☐ N ☐	Had a recent infectious disease?	Y ☐ N ☐
Had a recent injury?	Y ☐ N ☐	Have asthma/wheezing/shortness of breath?	Y ☐ N ☐
Have diabetes?	Y ☐ N ☐	Had seizures?	Y ☐ N ☐
Have frequent headaches?	Y ☐ N ☐	Wear glasses/contacts?	Y ☐ N ☐
Had fainting/dizziness?	Y ☐ N ☐	Passed out or chest pain with exercise?	Y ☐ N ☐
Had mononucleosis (mono) during past 12 mo.?	Y ☐ N ☐	Have problems with menstruation (if applicable)?	Y ☐ N ☐
Have problems with falling asleep/sleepwalking?	Y ☐ N ☐	Have back/joint pain?	Y ☐ N ☐
Have a history of bedwetting?	Y ☐ N ☐	Have problems with diarrhea/constipation?	Y ☐ N ☐
Have any skin problems?	Y ☐ N ☐	Traveled outside the country in the past 9 months?	Y ☐ N ☐

If "Yes", please explain: _____
_____
_____
_____
_____