



Day Camper Information Form

✓ Please complete & return by the FIRST DAY of Camp. Date of Enrollment _____

Camper's Name: _____
(First) (Middle) (Last)

___ Male ___ Female Birth Date _____ Age on arrival at camp _____
MM/DD/YY

Camper's Home Address: _____
Street Address City State Zip Code

✓ Parent or Guardian with Legal Custody to be contacted in case of illness or injury:

Name _____ Relationship to camper _____

Home Address _____
Street Address City State Zip Code

Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Parent(s) Employer _____

Employer Address _____
Street Address City State Zip Code

✓ Second Parent or Guardian or other emergency contact:

Name _____ Relationship to camper _____

Home Address _____
Street Address City State Zip Code

Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Parent(s) Employer _____

Employer Address _____
Street Address City State Zip Code

✓ Additional contact in event parent(s) or guardian cannot be reached:

Name _____ Relationship to camper _____

Home Address _____
Street Address City State Zip Code

Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Any special instructions o reach parent/guardian during camp hours: _____

✓ Person(s) other than parents/guardians designated to take child from camp:

Name Phone Number

Name Phone Number

✓ Persons NOT permitted to take child from camp: _____



Health Insurance & Medical Information

This Camper is covered by medical/hospital insurance ____YES ____NO

***Include a legible copy of both sides of your insurance card, if appropriate.**

Insurance Company _____ Policy Number _____

Subscriber # _____ Insurance Company Phone number (____) _____

Hospital of Choice _____ Phone (____) _____

Street Address City State Zip Code

Doctor _____ Phone (____) _____

Street Address City State Zip Code

Dentist _____ Phone (____) _____

Street Address City State Zip Code

Authorization for Emergency Medical Care

I hereby give my permission to La Foret and program staff to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child should an emergency arise. It is understood that La Foret and program staff will make a conscientious effort to locate the emergency contacts listed above before any action is taken. If such contacts cannot be made, I/we accept the responsibility for the expense of any emergency medical or surgical treatment.

Parent/Guardian Signature _____ Date _____

Authorization to Participate or Exclude Participation in Program Activities

I hereby give permission for my child to go on trips away from La Foret, whether on foot or by vehicle. I give permission for my child to participate in all camp activities with the exception of the following:

Parent/Guardian Signature _____ Date _____

Authorization for Routine Medical Care

I hereby give permission for the designated Health Supervisor to provide routine medical care for my child for such minor injuries as scrapes and bruises, and to dispense the following prescriptions and over the counter medications as prescribed or indicated by the presenting symptoms:

Parent/Guardian Signature _____ Date _____

Medication Camper Must Take:

Include here all prescription or regularly used over-the-counter medications. All medications must be in their original containers and properly labeled with the camper's name.

Medication	Dosage	Frequency	Prescribing Physician
Medication	Dosage	Frequency	Prescribing Physician
Medication	Dosage	Frequency	Prescribing Physician
Medication	Dosage	Frequency	Prescribing Physician

Medication camper may take if indicated:

_____ Ibuprofen (Advil, etc.)

_____ Tylenol

_____ Other

Parent/Guardian Authorization for Health Care: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached, in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a need to know basis with camp staff. I give permission to photocopy this form. The camp has permission to obtain a copy of my child's health record from the providers who treat my child and these providers may talk with the program's staff about my child's health status.

Parent/Guardian Signature _____ Date _____

Relationship to Camper _____

If for religious or other reason you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Allergies

___ No Known Allergies

___ This Camper is allergic to ___ Food ___ Medicine ___ Environment (insect stings, hay fever, etc.)

___ Other - Please describe what the camper is allergic to and the reaction seen: _____

Diet & Nutrition

___ This camper eats a regular diet.

___ This camper has special food needs - Please describe: _____

Restrictions

___ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

___ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations - Please describe: _____

Camper Health Statement

All information is required. This form or a similar form with the same information must be filled out and SIGNED by your DOCTOR/PHYSICIAN/NURSE PRACTITIONER within the last 12 months.

1. Past history of serious lacerations, injuries, illnesses or chronic medical problems:

2. Allergies or drug reactions:

3. Medication now being taken:

I have examined this person and found him/her to be in satisfactory physical condition and capable of active participation in a regular camping program, except as follows:

Physician Signature _____ Date _____

Printed Name _____ Phone (____) _____

Street Address City State Zip Code



Photographic Release for Minors

I hereby consent to and authorize the use and reproduction by La Foret Conference and Retreat Center, or anyone authorized by La Foret, of any and all photographs that have been taken of my child(ren) during stay on La Foret property, without compensation to me. All digital and analog negatives and positives, together with the prints, are owned by La Foret. La Foret reserves the right to use these photographs in any of its print or electronic publications.

La Foret shall have the right to assign its rights hereunder, without your consent, in whole or in part, to any person, firm or corporation. I hereby acknowledge that I have read and understood the terms of this release.

Child's Name _____

Parent/Guardian Signature _____ Date _____

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