**Camp HOPE for Children and Teens**

**Registration Form for May 6th-7th, 2023**(To ensure your reservation, please submit this form no later than **April 8th**. Please be aware we will try our best, but may not be able to accommodate late registrations. Thank you!)

Camper name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race (Optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(street) (city) (state) (zip) (county)

Parent/Guardian email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Email is main source of communication between parent/guardian and Camp HOPE Director

How did you hear about Camp HOPE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & age of person who died & relation to camper:

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

Date and cause of death\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please be sure the camper is aware of the actual cause of death, as it will be shared at camp.\*\*

Did the camper live with the person who died? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe their relationship:

Please describe any specific concerns or pertinent information – ie: inappropriate behaviors, remarriage, aggression:

Please describe any specific difficulty in school or in relationships with others:

(continued…)

Camper’s hobbies or special interests:

Has your child been in any support groups or sought counseling? If yes, please explain:

Names and ages of child’s living siblings:

Please describe your child:

Camper’s t-shirt size: Youth: ( ) small ( ) medium ( ) large

Adult: ( ) small ( ) medium ( ) large ( ) XL ( ) XXL

I give my child permission to receive emergency medical care: ( ) YES ( ) NO

Camp is striving to be gender inclusive. Would you prefer your child to stay in a cabin with:

⬜ Campers who identify as female

⬜ Campers who identify as male

⬜ Campers of all genders\*

\*We will do our best to accommodate this request. Please know that if we do not have enough campers who select this option in your age group we will be reaching out to make an individual plan to support your child’s safety and wellbeing.

Camper signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to camper\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The primary emphasis of Camp HOPE is to provide an opportunity to share experiences, make connections with others who have experienced similar losses, learn coping strategies and above all relax and enjoy nature. Camp HOPE and the programs presented are not intended to be used as a substitute for physician or psychiatric care. Participants understand that by enrolling they are agreeing to take part in the retreat voluntarily and remain responsible for their own physical and emotional choices. By signing this registration you are agreeing to release and hold harmless Camp HOPE and its representatives from any and all liability.  
All information is confidential.*

(continued…)  
  
**CAMPER HEALTH HISTORY FORM   
Session: Spring 2023**

This form is **required** and is to be filled in by parent/guardian

**Camper Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Person who died** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact** (if above can’t be reached) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Emergency contact phone number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Condition (Check)**

Frequent ear infections\_\_\_\_ Heart Defect/Disease\_\_\_\_ Asthma\_\_\_\_ Diabetes\_\_\_\_ Hepatitis\_\_\_\_ HIV\_\_\_\_

None\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies (check)**

Insect stings\_\_\_\_\_ Food\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hay fever/sinus\_\_\_\_\_\_ Poison Ivy\_\_\_\_ Meds\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# None\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Operations or serious injuries (dates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional information/treatment on any of the above or other chronic or recurrent conditions. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Immunizations up to date: yes\_\_\_ no\_\_\_ Date of last tetanus**\_\_\_\_\_\_\_\_\_\_\_\_

**Any medically prescribed meal plan or dietary restrictions**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior or emotional problems/treatment**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you carry family medical/hospital insurance?\_\_\_\_\_\_ Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please notify Camp HOPE if this camper is exposed to any communicable disease during the three weeks prior to camp attendance. Please advise if the camper is on medication for any communicable disease.**

## Important – MUST be completed for Attendance

This health history is correct and I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and necessary transportation 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 secure and administer treatment, including hospitalization for me/my child.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MEDICATION INFORMATION

May the Health Staff administer over the counter pain medication if needed? \_\_\_\_yes \_\_\_\_no

If yes – Tylenol (amount)\_\_\_\_\_\_\_\_\_\_\_\_\_ or Ibuprofen (Advil)(amount)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Staff will administer Epipen (>66 pounds) or Epipen JR (<66 pounds) for a major allergic reaction. Benadryl will be given for minor and major allergic reactions. Any comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benadryl Gel or Calamine Lotion will be used for itchy skin or bug bites. Any comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\***Please note: Parent/guardian will be contacted for any major medical concern that occurs at camp. Be sure we have a phone number to be able to reach you this weekend.

Is the camper currently taking any medication? \_\_\_\_yes \_\_\_\_no. Does he/she/they need medication at camp this weekend? \_\_\_\_yes \_\_\_\_no. If yes, please complete the remainder of this form.

(continued…)

ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO CAMP IN THEIR ORIGINAL, PROPERLY LABELED CONTAINER. THE CONTAINER SHOULD HAVE THE CORRECT NUMBER OF PILLS FOR THIS WEEKEND ONLY. ANY CHANGES FROM THOSE ON THE CONTAINER MUST BE VERIFIED IN WRITING BY A PHYSICIAN. IF CAMPER USES AN EPIPEN AND/OR BENADRYL FOR ALLERGIC REACTIONS, PLEASE BRING THESE TO CAMP. BE SURE THE EXPIRATION DATE IS CURRENT.

1. **All medications must be turned over to the health care staff at registration on Saturday. This is to be done in the Health Center.**
2. **All medications will be given by the Health Staff. Inhalers may be self administered with parent/guardian permission.**
3. **List the Medications/dosage the camper needs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Side effects:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Please note any special instructions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return this completed form no later than April 8, 2023 to:   
Camp HOPE, P.O. Box 84, Amherst, WI 54406 or camphope89@gmail.com**