The Disabilities Ministry
Toni's Camp Retreat 2024
Participant Registration Consent Form and Liability Waiver

Archdiocese of Atlanta

☐ **Camper** ☐ **Volunteer** ☐ **Nurse** ☐ **Core Team**

Participant's Name_____ **Birth Date** _____

☐ **Female** ☐ **Male** **Number of years attending Toni's Camp** _____

T-shirt Size **Adult:** small medium large XL XXL XXXL

Church/Parish_____**School Name** _____**Grade** _____

Parent/Guardian's Name_____

Number to Reach you on Sunday_____

Address_____

City_____ **State**_____ **Zip**_____

Home Telephone_____ **Cell Phone**_____

E-mail Address_____

I, (adult volunteer, parent or guardian's name)_____ grant permission for my participant/myself (participant's name)_____ to attend and participate in all activities at **Toni's Camp Retreat** sponsored by the Archdiocese of Atlanta at Camp Twin Lakes on the weekend of May 3-5, 2024. This activity will take place under the guidance and direction of the Archdiocese of Atlanta employees and/or volunteers.

As adult volunteer, parent and/or legal guardian, I remain legally responsible for any personal actions taken by myself or the above named participant.

I agree on behalf of myself, and my participant named herein, if that is applicable, to hold harmless, release and not to sue the Archdiocese of Atlanta or any of its clergy, pastors, volunteers, officers, directors, or agents or any chaperones or representatives
associated with the event for any claim for personal injury or damage to property that arise out of or are caused by the fault or negligence of myself or my participant or the fault or negligence of the chaperones or representatives of the Archdiocese of Atlanta associated with the event.

Signature_____ **Date**_____

Archdiocese of Atlanta

The Disabilities Ministry
Toni's Camp Retreat 2024
Camp Twin Lakes (Exhibit 2)
Archdiocese of Atlanta Release Form

This agreement must be read and signed for you/your child to be eligible to attend the RCAA Administrative Services, Inc. program Toni's Camp Retreat at Camp Twin Lakes. Your/Your Child's Name: _____

I. PARTICIPATION CONSENT I understand and certify that my/my child's participation in the and its activities at Camp Twin Lakes is completely voluntary. I have familiarized myself with the RCAA Administrative Services, Inc. program and activities at Camp Twin Lakes in which I/my child will be participating. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not limited to, the activities of horseback riding, high and low elements ropes course, swimming, archery, gardening, cooking, biking, sports, lake swimming, and boating. I acknowledge that although RCAA Administrative Services, Inc. and Camp Twin Lakes have taken safety measures to minimize the risk of injury to camp participants, RCAA Administrative Services, Inc. and Camp Twin Lakes cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for the RCAA Administrative Services, Inc. program at Camp Twin Lakes. Further, I attest that my health insurance will cover any medical and hospital expenses that I/my child incur and I have received approval from a doctor authorizing me/my child to participate in RCAA Administrative Services, Inc. activities at Camp Twin Lakes. I also agree to inform RCAA Administrative Services, Inc. of any activities in which I/my child may not participate. I understand and agree that my child will be in an environment that involves elements related to nature, camping or community living, such as insects and insect bites, sun exposure, or communicable illnesses, including, but not limited to COVID19.

II. LIABILITY RELEASE I, the undersigned, understand that occasionally accidents occur during camp activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, I agree to assume those risks and by signing this liability release, I intend to legally bind myself, my minor children, my heirs, executors, and administrators. I hereby release and forever discharge RCAA Administrative Services, Inc. and Camp Twin Lakes, and any of their clergy, pastors, volunteers, officers, directors, employees, partners, shareholders, board members, servants, agents and assigns from and against all claims, causes of action, damages, losses and/or expenses arising out of or relating to any injury, illness, or loss of any kind, known or unknown, including but not limited to injuries to property or person, to me/my child during or related to my/my child's attendance in the RCAA Administrative Services, Inc. program at Camp Twin Lakes.

III. MEDIA RELEASE I do___ I do not___ give RCAA Administrative Services, Inc. and Camp Twin Lakes the right to interview and/or to take photographs, audio or audio-visual recordings of me/my child to be used in promotional, educational or fundraising materials including, but not limited to videotapes, pamphlets and brochures. I understand my/my child's name may be used in connection with these materials. By signing this media release, I intend to legally bind myself, my minor children, my heirs, executors and administrators. RCAA Administrative Services, Inc. and Camp Twin Lakes shall have the right to use photographs or other images of me/my child in promotion, educational or fund-raising materials. I acknowledge that RCAA Administrative Services, Inc. or Camp Twin Lakes shall have all rights of copyright in and to such photographs and videotapes and may use such copyright fully. I also hereby release RCAA Administrative Services, Inc. and Camp Twin Lakes and its officers, agents and employees from all liability connected with the taking and use of these materials as is authorized by RCAA Administrative Services, Inc. and Camp Twin Lakes. In addition, I waive all rights, interest or claims for payment in connection with any exhibition or release of these materials. This consent is voluntary, and I give it in the interest of public information, education, the furtherance of the goals of these institutions, or other lawful purposes. I acknowledge that I have legal authority to sign this form on behalf of the minor whose name is mentioned above.

IV. PROGRAM AND OUTCOMES EVALUATION I do__ I do not__ give RCAA Administrative Services, Inc. and Camp Twin Lakes permission to survey me/my child in confidential and voluntary program evaluation at Camp Twin Lakes. I understand that my/my child's name will not be used in conjunction with surveys and the data collected will be used to improve programming at Camp Twin Lakes and other camps and programs.

V. DISPUTES I agree that any dispute concerning, relating, arising out of or referring to the subject matter of this contract shall be resolved exclusively by binding arbitration in Atlanta, Fulton County, Georgia. The arbitration shall be administered by JAMS and conducted before a single arbitrator in accordance with the JAMS Rules. The arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, conscionability or formation of this contract, including but not limited to any claim that all or any part of this contract is void or violable.

_____ _____

Parent/Guardian/Self Signature **Date**

The Disabilities Ministry
Archdiocese of Atlanta
2401 Lake Park Drive
Smyrna, Georgia 30080
(404) 920-7682

The Disabilities Ministry
Toni's Camp Retreat 2024
Participant Registration Consent Form and Liability Waiver

MEDICAL MATTERS
I hereby warrant that to the best of my knowledge, my participant is (I am) in good health, other than chronic conditions listed below, and I assume all responsibility for the health of the participant. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to transport my participant to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Participant Name_____

Home Telephone_____ **Cell Phone**_____

Family Doctor_____ **Phone**_____

Health Plan Insurance _____ **Policy or I.D. No.**_____

Medicaid or Medicare No. (If Applicable)_____

Signature_____ **Date**_____

MEDICATIONS: Do not put medication of any kind in the suitcases. Under NO circumstances is the participant to be responsible for his own medication. No medication, prescription or non-prescription, is allowed in the cabins. This rule applies to both campers and volunteers and is for the protection of all.

ALL medication must be sent to camp in the original containers. We must have complete labeling and physicians instructions. Please send only the necessary amount of medication needed for the Toni's Camp weekend.

My participant **WILL BE** bringing medication to camp. (This includes both prescription and non-prescription medication).

Signature_____ **Date**_____

CHOOSE ONE BELOW:
No medication of any type, whether prescription or non-prescription, may be administered to my participant unless the situation is life-threatening and emergency treatment is required.

Signature_____ **Date**_____

I hereby grant permission for non-prescription medication (such as ☐ Aspirin, ☐ Tylenol, ☐ Advil, ☐ throat lozenges and ☐ cough syrup, ☐ Benadryl or ☐ over-the-counter antihistamines) to be given to my participant, if deemed appropriate.

Signature_____ **Date**_____

The Disabilities Ministry
Toni's Camp Retreat 2024
Medication List and Instructions

Archdiocese of Atlanta

PARTICIPANT NAME: _____

IN CASE OF EMERGENCY CONTACT : _____

PHONE: _____ ALTERNATE PHONE: _____

Please list below all medications you will be sending to camp with complete names and instructions. Remember that all medications are to be given to the nurse or bus captain or camp director at the beginning of camp and must be in their original packaging with doctor instructions. Please send only what is required for the camp duration.

List names of each medication and concise directions for dispensing, including dosage and frequency of dosage, along with any special notes, such as: take with meals, milk or juice. NO PHARMACY LISTS WILL BE ACCEPTED.

Medications are given by medical staff, usually at mealtimes. Please let us know if you need a different schedule.

	MEDICATIONS	**SPECIAL INSTRUCTIONS**
Breakfast:		
Lunch Time:		
Dinner Time:		
Bedtime: (9:30 p.m.)		
As Needed:		

Signature _____ **Date** _____

SPECIFIC MEDICAL INFORMATION Camp Participant's NAME_____

We will take reasonable care to see that the following information will be held in confidence.

Disability if any _____

Allergic reactions (describe reaction and treatment) to things such as medications, foods, plants, insects, Latex, etc.

_____
_____
_____

Does participant have a medically prescribed diet? ☐ Yes ☐ No If yes, please describe _____

_____
_____
_____

Does participant have any physical limitations? ☐ Yes ☐ No If yes, please describe _____

_____

Does participant have a seizure disorder? ☐ Yes ☐ No If yes, please describe _____

_____

Is participant subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting, etc.? ☐ Yes ☐ No If yes, please describe _____

_____

Has participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, Covid, etc.? ☐ Yes ☐ No If yes, list date and disease or condition_____

_____

Participant has the following special medication conditions the staff should be aware of: _____

_____
_____
_____
_____
_____
_____
_____

Signature_____ Date_____

Archdiocese of Atlanta

The Disabilities Ministry
Toni's Camp Retreat 2024
Release, Waiver, Indemnification, and Health Affirmation For Camp Twin Lakes, Inc.

By signing this Release, Waiver, Indemnification, and Health Affirmation below, I intend to be legally bound hereby, for myself, my minor children, my wards, my heirs, executors, administrators, successors, and assigns, and in consideration of Camp Twin Lakes, Inc. ("CTL") permitting me/my child/my ward to attend and participate in activities at Toni's Camp Retreat and CTL's facility (collectively "Camp Twin Lakes"), I hereby release and forever discharge CTL, RCAA Services Inc. and any of their clergy, pastors, volunteers, officers, directors, employees, and agents (the "Released Parties") from and against any and all damages of any kind whatsoever arising out of any injury, illness, infirmity, disease, or loss of any kind, personal or property, to me/my child/my ward during or related to my/my child's/my ward's attendance at a camp at Camp Twin Lakes. I understand and certify that my/my child's/my ward's participation in Toni's Camp Retreat and its activities at Camp Twin Lakes is completely voluntary and I have familiarized myself with the Toni's Camp Retreat program and activities at Camp Twin Lakes in which I/my child/my ward will be participating. I recognize that certain hazards and dangers are inherent in Camp Twin Lakes activities and programs, and I acknowledge that the Released Parties cannot ensure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed my child or my ward, to the extent my child or ward will be attending and participating in activities at Camp Twin Lakes, in the importance of knowing and abiding by the rules, regulations, and procedures for Camp Twin Lakes. I also agree to defend, indemnify and hold the Released Parties harmless from and against any and all damages, costs, claims, demands, actions or causes of action sustained by any other person as a result of my/my child's/my ward's participation at Camp Twin Lakes, whether caused in whole or in part by the negligence of the Released Parties; provided, however, that this provision shall not operate to require indemnification of any gross negligence or willful misconduct of the Released Parties. Further, I attest that my health insurance will cover any medical and hospital expenses that I/my child/my ward incur and that I have received approval from a doctor authorizing me/my child/my ward to participate in the activities at Camp Twin Lakes. I further agree to inform Camp Twin Lakes of any activities in which I/my child/my ward is not to participate.

I have read and hereby accept the conditions described above. As an adult applicant, or the legal guardian of a minor applicant, I also give permission for myself or the minor child or ward to be treated by a doctor if needed.

Adult Signature _____

Name of Minor Child or Ward (if applicable) _____

Date _____

The Disabilities Ministry
Toni's Camp Retreat 2024
Camper Information

Archdiocese of Atlanta

Name of Camp Participant _____ **Nickname/Goes By**_____

Birth Date_____ **Age**_____ ☐ **Female** ☐ **Male**

Emergency Contact Name_____ **Telephone**_____

We ask that the information requested below be given by someone who knows the retreatant well (parent, guardian, brother or sister, house parent, friend or staff person). Even if you live independently, please have someone else complete this form. Please give us as much information as possible; anything which might help our staff in planning for and sharing this weekend.

Does this person usually take medication? ☐ Yes ☐ No

Will medication be brought this weekend? ☐ Yes ☐ No

Does this person know how to swim? ☐ Yes ☐ No

If yes, how well? _____

There will be no swimming; however, there will be supervised activities at the lake (boating, fishing and walking.)

Is this agreeable? ☐ Yes ☐ No

Religion:_____ **Does he/she receive the Eucharist?** ☐ **Yes** ☐ **No**

Classification of Disability

☐ **intellectual disability**	☐ **emotional disability**	☐ **blind/visually impaired**
☐ **deaf/hearing impaired**	☐ **autism**	☐ **cerebral palsy**
☐ **learning disability**	☐ **wheelchair**	☐ **other** _____

Daily Living Skills

Please give us as much information as possible. We need to know where assistance is needed and what the participant can be expected to do with no help. (*Please use back of form for additional information regarding DLS).*

	Independent	*Requires Assistance*	*Type of Assistance*
Ambulation			
Transfers			
Toileting			
Eating			
Dressing			
Bathing			
Grooming			
Communication			

Archdiocese of Atlanta

The Disabilities Ministry
Toni's Camp Retreat 2024
Camper Information

CAMPER NAME: _____

What are his/her special talents, interests and hobbies?

_____
_____
_____
_____
_____

How does this person communicate and/or relate to others?

_____
_____
_____
_____
_____

What type of discipline is most effective (when needed)?

_____
_____
_____
_____

To help your camp participant have an even better time, please tell us any likes or dislikes in food or activities; any special bedtime and/or mealtime routines, any fears, such as storms, the dark, or water; or anything else you want us to be aware of.

_____
_____
_____
_____
_____
_____
_____

This form has been completed by _____

Signature _____ **Date** _____

Relationship to participant _____

Archdiocese of Atlanta

The Disabilities Ministry
Toni's Camp Retreat 2024
Dress Code

Anyone associated with the Disabilities Ministry is expected to dress in good taste and in a manner which reflects the atmosphere of the Archdiocese of Atlanta. Modesty, cleanliness, and appropriateness are expected at all times.

Dressing in good taste is defined as follows:

1. Undergarments are not displayed (e.g. holes, tears, or outer garment material do not reveal undergarments, and bra straps are concealed by outerwear). Any sleeveless blouse or shirt must have a shoulder strap that is at least three fingers wide.
2. Shorts, skirts, and dresses are at a length that will allow the wearer's fingertips to touch the garment when arms and hands are fully extended, while standing. All forms of clothing cover the wearer's midriff, and, for females the chest/bust/cleavage area as well. The length of garments worn on the upper torso (i.e. shirts, tanks, blouses, sweaters) must cover or be covered by the wearer's waist band while standing.
3. Clothing must be worn that covers and rests upon or above a wearer's hips.

Bare feet are prohibited. Flip flops/sandals are highly discouraged.

Hats are not permitted for male communicants during Mass.

Clothing which displays alcohol, tobacco products, illegal drugs, satanic symbols, and inappropriate language and/or symbols, is not permitted during Ministry sponsored or supervised activities.

Compliance with directives of ministry officials in regards to the dress code is expected during ministry-sponsored or supervised activities. Failure to comply will result in disciplinary action up to and including immediate removal from ministry volunteer and service registries.

THIS FORM TO BE SIGNED BY ALL PARTICIPANTS

I have read and agree to abide by the dress code as required by the Disabilities Ministry of those who participate in ministry sponsored or supervised activities.

Participant Signature_____ Date_____

If the participant has not passed his or her 18th birthday, a parent or guardian's signature is required as well.

Parent's Signature_____ Date_____

The Disabilities Ministry
Toni's Camp Retreat 2024
General Information
(Keep this Page)

Archdiocese of Atlanta

Please Save This Information Sheet for Future Reference

Volunteers/counselors please try to arrive at 4 p.m. Camper check in is at 5 p.m. Do not drop off CAMPERS before 5 p.m. We will not have the staff to register them. THERE WILL BE NO CAMPER REGISTRATION BEFORE 5 P.M.

Dinner at camp is served promptly at 6 p.m. (whether we are there or not).

Families wishing to attend mass on Sunday at 10:00am MUST pre-register with Maggie Rousseau at: mrousseau@archatl.com.

After lunch on Sunday, May 5, we will close camp at 2 p.m. ***PLEASE DO NOT PLAN TO PICK UP YOUR CAMPER OR VOLUNTEER BEFORE CAMP ENDS.***

Clothing List
A "What to Bring" list is enclosed as a guideline. Everything on this list is not necessary, but has proved to work well for most campers. You know what your camper will or will not use. Please be sure to send an extra pair of shoes and do label all items, especially bedding, including pillows. A hat, to keep the sun off the face, can prevent bad sunburn. It is helpful to have you enclose the clothing list in the top of the suitcase, checking off the items and numbers sent, as a guide for packing to come home.

We have suggested a sleeping bag, but if you do not have one or prefer bedding, this is fine. If your camper is incontinent at night, sheets and a blanket that can be washed would probably work better.

Personal music and gaming devices may be used in the cabins only.

Spending Money
There is NO need for campers or counselors to bring money. We cannot be responsible for it.

Medication
Any participant that will need medication **must bring the medication with him/her in the original package, with the participants name, prescribing doctor and dosage visible on the container. Do not put medication of any kind in the suitcase. Under NO circumstances is anyone to be responsible for his own medication. No medication, prescription or over-the-counter, is allowed in the cabins.** This rule applies to both campers and volunteers/counselors and is for the protection of all. Please give medication directly to the nurse (or if riding the bus, the person in charge of the bus).

We need to be aware of all medical problems, such as heart disease, diabetes, epilepsy, allergy to bee or insect stings, etc., and the emergency procedure.

Pictures
We will be taking a group picture and you will be given an opportunity to see it as soon as it is ready.
If you do not want your camper's picture taken, please let us know and your wish will be respected.

To Reach Us at Camp Twin Lakes—Rutledge
Directions to Camp Twin Lakes can be found at : http://www.camptwinlakes.org/locations/rutledge.html
The telephone number is 706-557-9070, ext. 200. There will NOT be someone at this number at all times.
If you must reach us and cannot get an answer, please call Maggie Rousseau 770-714-8717. Cell service is spotty at times.

A CHECKLIST FOR PACKING—WHAT TO BRING AND WEAR

We hope this list will help you get ready for camp.

Everything on this list is not necessary. You know what your camper needs.

Please attach this inventory list to the top of the suitcase. It will help when preparing to return home.

LABEL ALL YOUR BELONGINGS

especially luggage, bedding and pillows.

Keep this Page

1. BEDDING
   - _____a. Sleeping Bag (2 single sheets and 2 blankets, if preferred)
   - _____ b. Pillow and Pillow Case (please label)
2. TOILETRY ITEMS
   - _____a. Toothbrush
   - _____b. Toothpaste
   - _____c. Hair brush and comb
   - _____d. Towels and wash cloths
   - _____e. Soap and Shampoo
   - _____f. Tissue
3. CLOTHING
   - _____a. Hat (to keep sun off face)
   - _____b. Jeans or slacks
   - _____c. Shorts
   - _____d. Shirts (at least one with long sleeves)
   - _____e. Pajamas
   - _____f. Socks
   - _____g. Underwear
   - _____h. Warm jacket or sweater
   - _____i. Raincoat or poncho
   - _____j. Swimsuit (to assist during showers)
   - _____k. Shoes (2 pairs)
   - _____l. Shower Cap
4. OPTIONAL ITEMS
   - _____a. Sunglasses
   - _____b. Sunscreen
   - _____c. Books or cards
   - _____d. Flashlight
   - _____e. Zip-lock bag for wet items
   - _____f. Umbrella
5. MEDICINE
   (DO NOT PACK IN SUITCASE—GIVE TO NURSE)
   - _____a._____
   - _____b._____
   - _____c._____

Camp begins Friday at 5pm and ends on Sunday at 2pm.

All cell phones and car keys will be collected at check-in and returned at check-out

CAMPER HEALTH HISTORY FORM1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

Mail this form to the address below by 3/01/24 ***(date)***

Maggie Rousseau
Toni's Camp Retreat c/o
Archdiocese of Atlanta
2401 Lake Park Drive
Smyrna, GA 30080

Dates will attend camp: from 5/3/24 (Month/Day/Year) to 5/5/24 (Month/Day/Year)

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

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

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 below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ InsuranceCompany Phone Number (____)_____

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/or an 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 my 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. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

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

Camper Name First _____ Middle _____ Last _____ (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (⋆) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster⋆ (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication:

☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Copyright 2014 by American Camping Association, Inc.

Rev.1/2014 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes ☐ No	11. Had fainting or dizziness?	☐ Yes ☐ No
2. Ever had surgery?	☐ Yes ☐ No	12. Passed out/had chest pain during exercise?	☐ Yes ☐ No
3. Have recurrent/chronic illnesses?	☐ Yes ☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes ☐ No
4. Had a recent infectious disease?	☐ Yes ☐ No	14. If female, have problems with periods/menstruation?	☐ Yes ☐ No
5. Had a recent injury?	☐ Yes ☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes ☐ No	16. Ever had back/joint problems?	☐ Yes ☐ No
7. Have diabetes?	☐ Yes ☐ No	17. Have a history of bedwetting?	☐ Yes ☐ No
8. Had seizures?	☐ Yes ☐ No	18. Have problems with diarrhea/constipation?	☐ Yes ☐ No
9. Had headaches?	☐ Yes ☐ No	19. Have any skin problems?	☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes ☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Rev.1/2014 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: _____ Initials: _____

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

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Recommendations for Licensed Medical Personnel

FORM 2

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

Mail this form to the address below by ~~3/01/24~~ 24 ***(date)***

Maggie Rousseau
Toni's Camp Retreat c/o
Archdiocese of Atlanta
2401 Lake Park Drive
Smyrna, GA 30080

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from 5/3/24 (Month/Day/Year) to 5/5/24 (Month/Day/Year)

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

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐No **(If "No," date of last physical:** _____ (Month/Day/Year)**)**

ACA accreditation standards specify physical exam within the last 12 months.

Weight: _____ lbs Height: ____ft____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list)***:

☐ To medications: ***(list)***:

☐ To the environment ***(insect stings, hay fever, etc.– list)***:

☐ Other allergies: ***(list)***:

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:(describe below)

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date:_____

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Camper Name First Middle Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):