

2016 Vacation Bible School at St. Matthew Lutheran Church

1505 Dover Street, Worthington, MN (507) 376-6168

June 13-16 (9am-3pm) and June 17 (9am-12noon at Pioneer Village)



Camp Omega

Traveling Day Camp

Camper Registration Form

Name _____

Address _____

City _____ State _____ Zip _____

Parents _____

Phone (C) _____ (W) _____ (H) _____

Congregation St. Matthew's Dates of Day Camp June 13-17, 2016

I hereby enroll and give permission for my child to participate in the planned activities of Camp Omega Day Camp, conducted in partnership with

St. Matthew Lutheran Church.

I understand I am responsible for transportation to and from Day Camp.

SIGNATURE OF PARENT OR GUARDIAN

X _____ DATE _____

Photography Release

I give permission and consent to allow photographs, videotapes, and interviews to be taken during the camp session. I further give consent that any such images or interviews may be published and used to illustrate and promote the camp and the National Lutheran Outdoors Ministry Association.

SIGNATURE OF PARENT OR GUARDIAN

X _____ DATE _____

Reverse Side MUST be completed also! THANK YOU!

Camp Omega Health Information Form

Camp Session Name & Date _____

Last Name _____ First Name _____ Gender M F Birthdate _____ Age _____

Name of Parent(s)/Guardian(s) (or Spouse) _____

Home Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Emergency Contact (other than parent/guardian) _____ Relationship _____

Phone Numbers: Home _____ Mobile _____ Work _____

Medical Insurance Co. _____ Policy/Certificate Number _____

Policy Holder's Name _____

Physician _____ Phone _____ Dentist _____ Phone _____

Medications Being Taken: List all medications (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period. Medications will be dispensed according to label instructions.

Medication #1 _____ Dosage _____ When taken each day _____

Medication #2 _____ Dosage _____ When taken each day _____

Medication #3 _____ Dosage _____ When taken each day _____

Are all immunizations require for school up to date? Yes or No Month & Year of Last Tetanus Shot _____ / _____

Health Information

General Questions (if "yes" explain below)	Yes	No
1. Has food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Must have a gluten free diet?	<input type="checkbox"/>	<input type="checkbox"/>
3. Must have a dairy free diet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is subject to fainting?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is subject to upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is subject to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a reaction to bee sting?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a reaction to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a reaction to poison ivy, oak or sumac?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a reaction to other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has had a recent injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>

General Questions continued...	Yes	No
14. Has a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
19. If female, has an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
20. Has a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
21. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
26. Has activity restrictions or limitations?	<input type="checkbox"/>	<input type="checkbox"/>

Please Attach a Copy of the Participants Immunization Records.

Explanations of activity restrictions or limitations if any: _____

Explanations of past medical treatment if any: _____

Explanation of any physical, mental, or psychological conditions requiring medication, treatment or restrictions if any: _____

Important - This Form Must Be Signed Prior To Participation!

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby authorize the Camp Omega staff to administer medications and first aid as deemed necessary well as authorize the medical personnel selected by the camp staff to provide routine health care and emergency medical care by medical staff to hospitalize, secure treatment for, order injection, anesthesia, blood transfusions, or surgery, and to release any records necessary for insurance purposes as well as provide or arrange necessary related transportation for the above named participant. This form may be photocopied.

Photo Image Release: As a participant in a Camp Omega event, I give permission and consent to allow photos, videos, and interviews to be taken of the above mentioned individual during the camp session. I further give consent that any such images or interviews may be published in a variety of ways and used to illustrate and promote Camp Omega and the National Lutheran Outdoors Ministry Association.

★ **Signature** of parent/guardian or adult guest/staff _____ Date _____

For Camp Use -

Updates / Additions to health history noted [] Yes [] No [] None Required

Notes: _____

Who's Picking Up Your Child?

Camper Name: _____

Grade: _____

Day Camp Site: _____

Adults Authorized For Camper Pickup:

You may list as many people as you would like.

1 _____

2 _____

3 _____

X: _____ Your Signature

Check Out - Sign Out

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Who's Picking Up Your Child?

Camper Name: _____

Grade: _____

Day Camp Site: _____

Adults Authorized For Camper Pickup:

You may list as many people as you would like.

1 _____

2 _____

3 _____

X: _____ Your Signature

Check Out - Sign Out

Monday _____

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