2017 CAMP WARWICK REGISTRATION FORM*

THIS FORM MUST BE COMPLETED BY PARENT/ GUARDIAN AND SUBMITTED WITH THE SEPARATE NOTARIZATION FORM (PAGE 5) BEFORE REGISTRATION WILL BE ACCEPTED.
THE PERSON REGISTERING THIS CAMPER IS RESPONSIBLE FOR MAKING ALL PAYMENTS.

Please use one form per child. Copies may be made of this form.

**Please contact the Registrar's office for a Camp Sunrise application packet.*

PRINT NEATLY WTH BLUE OR BLACK INK. FILL IN **ALL** INFORMATION

CAMPER INFORMATION (WHERE CAMPER RESIDES)

Is this the camper's first summer at Camp Warwick? ❑ Yes ❑ No Grade Completed _____ ❑ Male ❑ Female

Camper Birth Date ____/____/____ Camper Age: _____

Last Name _____ First Name _____ Initial _____

Parent/Guardian Full Name(s) _____

Mailing Address _____

City _____ State _____ Zip _____

Name of Person Registering this Camper _____

Relationship to Camper _____

Registrant's Phone Number _____ Email _____

Camper lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other_____

Please place a check next to the number that is best to use as a first contact.

❑ Home Telephone _____

❑ Mother's Work Telephone _____ ❑ Father's Work Telephone _____

❑ Mother's Cell Phone _____ ❑ Father's Cell Phone

_____

Mother's Email _____ Father's Email _____

How did you learn about Camp Warwick (i.e., referral, advertisement, church)? _____

_____

CHURCH INFORMATION (If applicable)

Church Name _____

❑ Reformed Church in America ❑ Other Denomination _____

Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION REQUIRED* (LIST INDIVIDUALS OTHER THAN PARENT/GUARDIAN)

Emergency Contact #1 _____ Telephone _____

Relationship to Camper _____

Emergency Contact #2 _____ Telephone _____

Relationship to Camper _____

Send Registration, Health Record and Notarization Form with full payment to:
CAMP WARWICK, REGISTRAR, P. O. Box 349, WARWICK, NY 10990
Payment Options: Checks payable to the **Warwick Conference Center, Inc.**
Credit Card: Visa or Mastercard

2017 CAMP WARWICK HEALTH RECORD

THE HEALTH RECORD MUST BE COMPLETED IN FULL AND INCLUDED WITH THE REGISTRATION FORM AND THE SIGNED NOTARIZATION FORM BEFORE REGISTRATION WILL BE ACCEPTED.

Camper Last Name _____ Camper First Name _____ Initial _____

Family Physician _____ Physician's Telephone _____

Health Insurance Co. _____ Type of Policy _____ Policy # _____

Policy Holder Name and Address _____

Policy Holder's Date of Birth ___/___/___ Name of Employer Associated with Policy _____

Attach a photocopy of the insurance card (front and back). Employer Phone # _____

Prescription drug policy? ❑ Yes ❑ No If yes, attach a photocopy of the prescription card (front and back).

PLEASE NOTE: The Warwick Conference Center / Camp Warwick is not responsible for the cost of prescriptions, doctor visits, or emergency room visits during your camp stay.

*** FILL IN ALL INFORMATION ***

MEDICAL INFORMATION

Is your child in general good health and able to participate in all normal camp activities? ❑ Yes ❑ No

ADD	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Throat problems	❑ Yes ❑ No
ADHD	❑ Yes ❑ No	As infant	❑ Yes ❑ No	Respiratory problems	❑ Yes ❑ No
Seizures/Epilepsy	❑ Yes ❑ No	Current problems	❑ Yes ❑ No	Diabetic	❑ Yes ❑ No
Dizzy spells	❑ Yes ❑ No	Chest Pain	❑ Yes ❑ No	Special diet	❑ Yes ❑ No
Motion sickness	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Frequent nausea	❑ Yes ❑ No
Chronic back pain	❑ Yes ❑ No	Low/high blood pressure	❑ Yes ❑ No	Jaundice/Hepatitis	❑ Yes ❑ No
Neck pain	❑ Yes ❑ No	Ear infections	❑ Yes ❑ No	Difficulty urinating	❑ Yes ❑ No
Homesickness	❑ Yes ❑ No	Hearing problems	❑ Yes ❑ No	Kidney infection	❑ Yes ❑ No
Special needs	❑ Yes ❑ No	Vision problems	❑ Yes ❑ No	Hernia	❑ Yes ❑ No
Hyperactive	❑ Yes ❑ No	Severe menstrual cramps	❑ Yes ❑ No	Behaviorial Issues	❑ Yes ❑ No
Emotional Issues	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Digestive Issues	❑ Yes ❑ No

Auto-Immune Conditions ❑ Yes ❑ No

FOR GIRLS: Been told about menstruation? ❑ Yes ❑ No Has menstruated? ❑ Yes ❑ No

Please give specific information and current status regarding any items marked "yes" above.

_____

_____

_____

MEDICAL HISTORY - PLEASE LIST DETAILS & DATES BELOW. USE ADDITIONAL SEPARATE PAGE IF NEEDED.

Have you ever been hospitalized? ❑ Yes ❑ No If yes, reason and date: _____

Chronic recurring illness _____ Any broken bones _____

Severe head, neck or back injury_____ Date:_____

Contagious diseases _____ Date:_____

Serious operations (list date/type)_____ Date:_____

Recent illness/injury_____ Date:_____

Please submit statement of how your child has been medically treated and with what medication.

CAMPER NAME _____

Please check the weeks your child wishes to attend camp.

IN CAMP

❑	WEEK 1	June 25-30	Grades 3-5 & 6-9	Camp Fee: $425.00	$_____
❑	WEEK 2	July 02-07	Grades 3-5 & 6-9	Camp Fee: $425.00	$_____
❑	WEEK 3	July 09-14	Grades 3-5 & 6-9	Camp Fee: $425.00	$_____
❑	WEEK 4	July 16-21	Grades 2-4	Camp Fee: $425.00	$_____
❑	WEEK 5	July 23-28	Grades 5-8 & 9-12	Camp Fee: $425.00	$_____
				IN CAMP FEE(S):	$_____

OPTIONAL HORSEBACK RIDING OPPORTUNITIES FOR IN CAMPERS will be available for an addtional fee:

❑	WEEK 1	June 25-30	ONE DAY	Additional Fee: $ 55.00	$_____
❑	WEEK 2	July 02-07	FULL WEEK	Additional Fee: $215.00	$_____
❑	WEEK 3	July 09-14	FULL WEEK	Additional Fee: $215.00	$_____
❑	WEEK 4	July 16-21	ONE DAY	Additional Fee: $ 55.00	$_____
❑	WEEK 5	July 23-28	FULL WEEK	Additional Fee: $215.00	$_____
				HORSEBACK RIDING FEE(S):	$_____

IN CAMP / HORSEBACK RIDING FEE(S) SUBTOTAL: $_____

Amount church will contribute (check must accompany registration form): $_____

OVERNIGHT CAMP FEE(S) TOTAL: $_____

BUNK PARTNER PREFERENCE (one name only): _____

DAY CAMPS: ADVENTURE CAMP & DAY CAMP

Please check off below the camp week(s) your child wishes to attend. **FULL PAYMENT FOR THE FIRST WEEK** your child wishes to attend must accompany registration. For each additional week your child wishes to attend, please remit a $40.00 non-refundable deposit. **Adventure Camp Fee is $330.00 per week***. **Day Camp Fees are $300.00 per week for the first child and $275.00 per week for each additional child**. Registrations for **THREE or more weeks** of Day Camp and Adventure Camp **PAID IN FULL at the time of registration by May 31st** will receive an additional 5%** discount.

**There is no second child discount for Adventure Campers. **5% Discount: Day Camp - Subtract $15.00 per week for 1st child; subtract $13.75 per week for additional children. Adventure Camp - Subtract $16.50 per week. Please contact the Camp Registrar with any questions.*

Please check one: ❑ Day Camp ❑ Adventure Camp

❑ This registration form utilizes the additional child discount.

DAY CAMP FEES

❑	WEEK 1	June 26-30	
❑	WEEK 2	July 03-07	
❑	WEEK 3	July 10-14	
❑	WEEK 4	July 17-21	
❑	WEEK 5	July 24-28	
❑	WEEK 6	July 31-Aug. 04	
❑	WEEK 7	August 07-11	

PARTIAL PAYMENT OPTION

First Week Fee: $_____

Additional weeks deposit fee (# of weeks @ $40.00 per week): $_____

TOTAL FEES: $_____

DAY CAMP FEE(S) TOTAL:

PAID IN FULL OPTION

PAID in FULL Amount: $_____

Circle # of weeks

Paid In Full: 3 4 5 6 7

TOTAL FEES: $_____

$_____

PAYMENT OPTIONS

____ Check Enclosed. ____ Credit Card Please bill $ _____ to my VISA or MASTERCARD (circle one)

Credit Card #_____ Exp. Date _____ Cardholder Signature _____

Credit Card Billing Address (Required) _____

Street City State Zip

CAMP FEE MUST ACCOMPANY THIS REGISTRATION, unless you are applying for a scholarship. Health forms must be filled out completely, and all registration items submitted in order to hold your space. You will receive a confirmation mailing confirming the week(s) you are registered within four weeks of receipt of your registration.

SCHOLARSHIPS ARE AWARDED FOR OVERNIGHT CAMPS ONLY

Scholarships are available through the generosity of the Synod of New York, Reformed Church in America; Reformed Church of Port Ewen Scholarship Fund; Jeremy P. Nulton Scholarship Fund; Rev. Herman De DeJong Scholarship Fund; Henriettta A. Wermann Scholarship Fund; and Joyce Weissert Memorial Scholarship Fund.

*FILL IN **ALL** INFORMATION*

CAMPER NAME: _____

FOOD ALLERGIES

List food(s) your child is allergic to: _____

_____

What type of reaction does your child experience when ingesting these foods?

Hives ❑ Yes ❑ No Anaphylactic Shock ❑ Yes ❑ No GI Disturbance ❑ Yes ❑ No

What treatment is given?

None ❑ Yes ❑ No Benadryl ❑ Yes ❑ No Epi-pen* ❑ Yes ❑ No

Is your child able to self-administer epi-pen? ❑ Yes ❑ No Other: _____

_____

Requires a doctor's order. Complete Medical Authorization Form sent in confirmation packet.

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life-threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attending camp to discuss specific arrangements at 845-986-1164. Ask for Arlene Tenckinck.

SKIN ALLERGIES

❑ Yes ❑ No If "yes", please list:_____

_____

MEDICATION ALLERGIES

List any prescription or over-the-counter medications that your child is allergic to: _____

_____

_____

OTHER ALLERGIES

Bee Sting ❑ Yes ❑ No Poison Ivy/Oak/Sumac ❑ Yes ❑ No

Hay Fever ❑ Yes ❑ No Suntan Lotion ❑ Yes ❑ No

Reaction: _____

Treatment: _____

IMMUNIZATIONS

New York State requires your child to have the following immunizatons. **PLEASE ATTACH AN OFFICIAL IMMUNIZATION RECORD FROM THE CHILD'S DOCTOR'S OFFICE.**

DPT Varicella M.M.R. Hepatitis B Series Oral Polio Vaccine HIB

All immunizations are required unless a) it is medically contraindicated (doctor's signature required) or b) choose not to for religious reasons (documentation by religious leader necessary).

MEDICATIONS / CAMP WARWICK CAMPERS - USE ADDITIONAL SEPARATE PAGE IF NEEDED

List any medication (prescription and over-the-counter) that your child is currently taking: _____

_____

_____

I give permission to the Camp Warwick Health Director to supervise the self-medication of the following: *(Check off)*

❑ Antacids / Tums ❑ Cold medications ❑ Tylenol ❑ Ibuprofen (Advil or Motrin)

❑ Cough syrup/drops ❑ External ointments ❑ Suntan lotion ❑ Benadryl

Other over-the-counter medications (list):_____

_____

The Camp Warwick Health Director will supervise the self-medication of prescription and over-the-counter medicines by campers at on-site camps and oversee the First Aid personnel of off-site camps in the distribution of medicine. All medications (prescription and over-the-counter) must be given to the Health Director at the time the camper checks in. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. All prescription medications must be in the original container, labeled with the camper's name, and written instructions signed by your physician must accompany the medication. All over-the-counter medications must be in the original container and labeled with the camper's name. A **USE OF MEDICATION POLICY**

2017 CAMP WARWICK NOTARIZATION FORM

THIS FORM MUST BE COMPLETED BY PARENT/ GUARDIAN AND NOTARIZED BEFORE REGISTRATION WILL BE ACCEPTED.

Please use one form per child. Copies may be made of this form.

CAMPER INFORMATION

Camper Last Name _____ Camper First Name _____ Initial _____

Parent/Guardian Full Name _____

Best Telephone Number to reach Parent/Guardian: _____

EMERGENCY CONTACT INFORMATION* (*if parent/guardian cannot be reached*) Please use the SAME emergency contact information as provided on Page 1.

Emergency Contact #1 _____ Telephone _____

Relationship to Camper _____

Emergency Contact #2 _____ Telephone _____

Relationship to Camper _____

If camper is residing with a friend or relative other than parent/guardian during the week they are attending camp, please list that individual as Emergency Contact #1.

CAMP WARWICK REGISTRATION & HEALTH RECORD CONSENT RELEASE

In signing this release, I certify that the information on the Camp Warwick Registration Form and Camp Warwick Health Record is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by The Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child/ward, as named herein. I understand that I am responsible for the cost of prescriptions, doctor visits and/or emergency room visits during my child/ward's stay at Camp Warwick. I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by my child/ward at on-site camps and supervise the First Aid Personnel of off-site camps in the distribution of medicines. I give permission for my child/ward to be transported in the Warwick Conference Center vehicles to and from public transportation. I give permission for my child/ward to be transported in the Warwick Conference Center vehicles as necessary for approved off-site camp activities. I authorize the use of photographs and videos of my child/ward in camp publicity.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

NOTARIZED HOSPITAL RELEASE STATEMENT REQUIRED BY THE MEDICAL FACILITY AND CAMP WARWICK.

ACKNOWLEDGEMENT BY INDIVIDUAL

STATE OF *)*

SS:

COUNTY OF)

On this (day) _____ (month of) _____, (year)_____, before me personally came _____, to me known and known to me to be the person described in and who executed the forgoing instrument and he/she acknowledged to me that he/she executed the same.

_____

Notary Public

USE OF MEDICATIONS POLICY

* The administration of prescribed medication to a camper during camp hours will be permitted only when failure to take such medicine would jeopardize the health of the camper, or the camper would not be able to attend camp if the medicine were not made available during camp hours.

* For purposes of this policy, "**medication**" shall include all medicines prescribed by a physician or a nurse practitioner.

* **Before any medication can be administered or self-administered to any campers, Camp Warwick shall require the written request of the parent and the written order of the prescribing physician. Both documents shall be kept on file in the infirmary.**

* **Only medication in its original prescription bottle, labeled with the date of prescription, camper's name, and exact dosage will be dispensed in the Camp Infirmary.** Only the Health Director will supervise the self-medication of prescription and over-the-counter medications by campers.

* No camper is to have any other type of medication (aspirin, diet pill, antihistamine, etc. on his/her person at camp under any circumstances; the only exception to this would be an inhaler or an epi-pen. **All inhalers and epi-pens must be labeled with the child's name and must be accompanied by the Medication Authorization form**. If situations arise where such medication may be needed, the Camp Nurse is to be consulted. Campers who are observed with medication or taking medication are to be reported to the Director immediately.

* This form will be placed on file in the Camp Infirmary. **Should the medication, dosages, or instructions change, a new form must be completed by your physician and given to the Camp Nurse.**

AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS

INSTRUCTIONS

1. Read the following carefully.
2. Complete the AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS form below and obtain your physician's signature.
3. Either send this form to the Camp Registrar or bring it with you when you register at check-in.
4. A camper who requires medication **MUST** either send the form (below) to the Camp Registrar or present the form at registration.

WHEN BRINGING MEDICATIONS TO CAMP:

1. **ALL** medications **MUST** be brought to camp in the original container dispensed from the pharmacy with the proper labeling.
2. The medication should be brought to camp accompanied by **A COPY OF THIS FORM** . Be sure you have included all of the following information: a) camper's name, b) name of drug, c) dosage and frequency, d) doctor's name, address and telephone number, e) possible side effects, f) condition being treated and g) doctor's signature.

TO BE COMPLETED BY PARENT/GUARDIAN

I request that _____, age _____ receive the medication as prescribed below by his/her physician. This medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Camp Nurse or other designated person will administer the medication. My physician has also completed the over-the-counter medication authorization for this camper. I understand that unless otherwise indicated, the Camp Nurse will administer over-the-counter medications as needed.

_____ _____ _____

Parent/Guardian Signature | Telephone Number | Date

TO BE COMPLETED BY PHYSICIAN

I request that my patient, listed below, receive the medication(s) as listed below.

_____ _____

Patient Name | Age

NAME OF MEDICATION	PRESCRIBED DOSAGE & MEANS OF ADMINISTERING	TIME TO BE ADMINISTERED	EXPECTED DURATION OF TREATMENT	POSSIBLE SIDE EFFECTS & ADVERSE REACTIONS

PHYSICIAN NAME (printed) _____ DATE _____

Physician Signature: _____ Telephone Number: _____

Office Hours: _____

2017

$30.00 OFF

TAKE $30.00 OFF YOUR 2017 CAMP WARWICK REGISTRATION COST!

- This coupon is valid for one-time use through April 14, 2017 for any overnight camp or day camp.
- **This coupon must accompany your registration form. Your regisration form must be completed in full, with full payment** (less the $30.00 coupon amount).
- Your registration must be postmarked by April 14, 2017.
- Refunds will not be given if the coupon arrives after the registration has been received.
- Only one ORIGINAL $30.00 coupon may be used per camper (photo copies will not be accepted).
- This coupon cannot be combined with any other coupons or offers.

CAMP WARWICK REGISTRATION QUICK CHECK!

Did you enclose EVERYTHING needed for Registration?

Each Camper's Registration **MUST** include **ALL** of the items listed below *at the time of registration*.

_____ Notary Public's Signature/Stamp

_____ Copy of camper's Immunization Record from Doctor's Office

_____ Copy of camper's Health Insurance card(s) and Prescription Medicine Card (if applicable)

_____ Health Form filled out completely!

_____ Registration Form filled out completely!

_____ Overnight Camps: FULL payment is due at time of registration.

_____ Day Camps: FULL payment for the first week's Day Camp AND deposits for all *additional* Day Camp weeks are due at time of registration.

NOTE:

- If payment is to be made from an agency, church, or other third party, please provide us with details. Checks are to be made out to The Warwick Conference Center, Inc.
- Please remember that all Prescription Medication forms must be signed by the camper's doctor and are due at check-in.

Parent/Guardian Signature_____

Date_____