Mark A. Butler
Sheriff

WARREN COUNTY SHERIFF'S OFFICE
YOUTH SUMMER CAMP

_____
Camp Year

REGISTRATION FORM

CHILD'S NAME: _____ BIRTHDATE: _____
LAST FIRST MIDDLE

SEX: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

PARENT OR GUARDIAN: _____ PHONE: (_____) _____

HOME ADDRESS: _____ CELL: (_____) _____
STREET AND NUMBER

WORK: (_____) _____

_____
CITY STATE ZIP EMPLOYER: _____

SECOND PARENT OR GUARDIAN OR EMERGENCY CONTACT: _____

HOME ADDRESS: _____ PHONE: (____) _____
STREET AND NUMBER

CELL: (____) _____

_____
CITY STATE ZIP WORK: (____) _____

EMPLOYER: (____) _____

IN CASE OF AN EMERGENCY AND I CANNOT BE CONTACTED NOTIFY:

NAME: _____ PHONE: (____) _____

ADDRESS: _____
STREET AND NUMBER CITY STATE ZIP

T-SHIRT SIZE (S, M, L, XL) _____ (Adult Sizes Only)

IF 5TH GRADER OR 7TH GRADER, PLEASE LIST SCHOOL YOU WILL BE ATTENDING NEXT YEAR: _____

_____

HEALTH HISTORY

PLEASE CHECK APPROPRIATE BOXES

FREQUENT EAR INFECTIONS _____ HEART DEFECT/DISEASE _____ DIABETES _____
CONVULSIONS _____ BLEEDING/CLOTTING DISORDERS _____ HYPERTENSION _____
LICE _____

DISEASES/ALLERGIES/OTHER

PLEASE CHECK APPROPRIATE BOXES AND GIVE APPROXIMATE DATES

CHICKEN POX _____ MEASLES _____

GERMAN MEASLES _____ MUMPS _____

Health History Continued:

HAYFEVER _____ POISON IVY OR OTHERS _____ BEE OR INSECT STINGS _____

ASTHMA _____ PENICILLIN _____ OTHER DRUGS _____

HAS THIS CHILD EVER REQUIRED ANY PSYCHIATRIC COUNSELING OR HOSPITALIZATION? IF SO, FOR WHAT?
_____

LIST OPERATIONS OR SERIOUS INJURIES (DATES): _____

LIST DISABILITIES OR RECURRING ILLNESSES: _____

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN'S ADVICE? _____

LIST CURRENT MEDICATIONS AND INSTRUCTIONS FOR ADMINISTERING _____

ANY SPECIFIC DIETARY NEEDS? _____

(FOR FEMALE) HAS THIS CHILD MENSTRUATED? _____ IF NOT, HAS SHE BEEN TOLD ABOUT IT? _____
IF SO, IS HER MENSTRUAL HISTORY NORMAL? _____ SPECIAL CONSIDERATIONS? _____

PHYSICAL HANDICAPS NO_____ YES _____ ASSISTANCE NEEDED _____

HEARING IMPAIRMENT NO _____ YES _____ ASSISTANCE NEEDED _____

VISION IMPAIRMENT NO _____ YES _____ ASSISTANCE NEEDED _____

EMERGENCY MEDICAL AUTHORIZATION

I, _____, THE PARENT/GUARDIAN OF _____
DO HEREBY REQUEST, AUTHORIZE, AND GIVE PERMISSION OF THE YOUTH SUMMER CAMP, THE WARREN COUNTY SHERIFF'S OFFICE, OR DULY AUTHORIZED REPRESENTATIVES, TO ACT ON MY BEHALF AND IN MY STEAD, SHOULD MY SON/DAUGHTER COMPLAIN OF BEING ILL, BE INJURED OR REQUIRE EMERGENCY OR OTHER MEDICAL CARE, INCLUDING HOSPITALIZATION, DURING THE YOUTH SUMMER CAMP. I UNDERSTAND THAT IN THE EVENT THAT MY SON/DAUGHTER COMPLAINS OF BEING ILL OR IS INJURED DURING THE CAMP, HE/SHE WILL BE LOOKED AT BY EMT'S, OR NURSES ON STAFF AND TRANSPORTED TO WARREN MEMORIAL HOSPITAL EMERGENCY ROOM, IF NECESSARY.

I AGREE TO HOLD HARMLESS THE YOUTH SUMMER CAMP, THE WARREN COUNTY SHERIFF'S OFFICE, ITS OFFICERS, DIRECTORS, EMPLOYEES, ADMINISTRATORS, AGENTS, SUCCESSORS AND ASSIGNS FROM ALL CLAIMS, DEMANDS, DAMAGES, ACTIONS OR CAUSES OF ACTION, PRESENT OR FUTURE. WHETHER KNOWS, ANTICIPATED OR UNANTICIPATED, AND RESULTING FROM, RISING OUT OF, OR INCIDENT TO THEIR ACTIONS PURSANT TO THIS AUTHORIZATION.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

THE ABOVE INFORMATION IS CORRECT SO FAR AS I KNOW, AND THE PERSON LISTED ABOVE HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

I ALSO UNDERSTAND AND AGREE TO ABIDE WITH THE RESTICTIONS PLACED ON MY CAMP ACTIVITIES.

_____ _____
SIGNATURE OF CAMP PARTICIPANT DATE

IS YOUR CHILD COVERED BY HEALTH INSURANCE? YES _____ NO _____

IF YES, BY WHAT COMPANY? _____ POLICY HOLDER: _____

POLICY NUMBER: _____