

# 2019 Camp Calvary Adventure Camp Retreat Camper Registration

Space is limited for each retreat so please register early. Please register for only the weeks your camper plans to attend. If you choose a weekend that is already full, we will contact you and work out another date. Confirmations will be mailed after registration is received. There is a 30 camper limit per weekend, 15 male and 15 female.

**The cost for EACH retreat is \$100 which includes a t-shirt, group picture and buddy picture.**

\_\_\_\_\_ March 29-31 – Steve Rucker  
 \_\_\_\_\_ April 26-27 – Will Cooper  
 \_\_\_\_\_ May 24-26 – Jairus McLaughlin

Please contact Camp Calvary to inquire  
 about camps and availability.  
 859-375-4376

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**Please fill out this form completely!** If the information requested is not applicable, simply place “N/A” in the blank. If, in the course of the admissions process, it is determined that information provided is not adequate for the necessary care of the camper, the camper may miss an opportunity to attend the session they desire. **A camper’s opportunity to attend is based upon the information provided and availability of staff to meet care requirements.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Gender: M F

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Shirt Size: Sm. Med. L. XL XXL XXXL

**Primary Contact Information (Parent, social worker or agency representative):**

Agency/Facility Name: \_\_\_\_\_ Agency Phone: \_\_\_\_\_

Agency Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Primary Contact or Person Submitting this Form’s Name: \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Parent/Guardian/Caretaker \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Previous Camping Experience? Y N Where \_\_\_\_\_

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### *Emergency Contacts*

Please provide at least one emergency contact person in the event that we cannot reach the Primary Caregiver.

1. Name \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_ Alt.(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

2. Name \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_ Alt.(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

## *Medications*

Please fill out the Medications sheet including both prescription and non-prescription medications. All medications and a list of those medications (and tobacco products) will be turned over to the staff at the time the Camper is registered. If the camper requires any additional treatments or devices that must be administered by a qualified staff person, this must be brought to the attention of the medical staff at the time of check in. All medications (including non-prescription) will be dispensed by the designated member of the staff. **Also, to aid in the smooth transition of the Camper, we ask that all medications (up to and including the 8 pm dosage) be dispensed before leaving the Camper in the care of Adventure Camp staff.**

Please list additional medications on another page to give to the Adventure Camp Staff.

Does the camper use tobacco products?    YES            NO

*(Smoking is prohibited in all buildings and only allowed in designated areas)*

1. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

2. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

3. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

4. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

5. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

6. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

7. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

8. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

9. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

10. Medication: \_\_\_\_\_

Dosage/Frequency: \_\_\_\_\_

\*A current list of medications will be required when the camper arrives

**Primary Care Physician Contact Information**

In the event that the Camper goes to the emergency room, we would like to have their Primary Doctor's contact information.

Doctor's Name: \_\_\_\_\_

Doctor's Phone Number: (\_\_\_\_) \_\_\_\_\_

Doctor's Street Address: \_\_\_\_\_

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**Parent/Guardian/Caregiver**

It is most important that you provide essential information about the Camper's disabilities and specific needs. This is the information that we will use in arranging specific provisions for the Camper. **Registrations that do not provide information regarding disabilities will not be processed and notification will be made to the person responsible for filling out the form.**

Disabilities (List All)

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

Disability Involves (circle): Legs: R L, Arms: R L, Hands: R L, Head Breathing

Mobility: \_\_\_Independent with: \_\_\_Assistance \_\_\_Walker \_\_\_Crutches \_\_\_Wheelchair; \_\_\_Electric

**For non-ambulatory campers, it is the responsibility of the parent/guardian/caregiver to provide a wheelchair (and/or necessary augmentative devices) that is safe and in optimum operational condition. Be certain that wheels, brakes and seatbelts are safe and fully operational.**

Vision (circle): Normal Glasses Contacts Vision Impaired Legally Blind

Hearing (circle): Normal Hearing Impaired Deaf Uses Hearing Aids(bring extra batteries)

Communication (circle): Verbal Sp. Difficulty Nonverbal Signs Gestures

Seizure Disorder: Type and Frequency: \_\_\_\_\_

Date of Last Seizure: \_\_\_\_\_ Wears Helmet: Y N

Special Care for Seizures: \_\_\_\_\_

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

Allergies: \_\_\_\_\_

Precautions/Special Instructions: \_\_\_\_\_

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

*Personal Care Information*

**Personal Care (circle one): Independent                      Requires Assistance                      Dependent**

Level of care Required:

Bathing: \_\_\_\_\_

Toileting (circle one): Uses Urinal/Toilet      Uses Bedpan      Catheterizes Self      Must Be Catheterized

Wears "Depends"      Prompts after Toileting      Assistance after Toileting

Mealtime (circle one): Uses Utensils      Uses Fingers      Special Container      Requires Bib      Uses Straw

Dietary Restrictions: \_\_\_\_\_

\_\_\_\_\_

Special Foods/Textures: \_\_\_\_\_

\_\_\_\_\_

Nighttime (circle): Night Incontinence      Wears "Depends"      Gets up during the night

Develops bedsores      Sleeps on: Back      Stomach      Side ( R L)

Other Considerations: \_\_\_\_\_

Activities Camper shouldn't engage in: \_\_\_\_\_

\_\_\_\_\_

Discipline/Inappropriate Behavior Concerns: \_\_\_\_\_

\_\_\_\_\_

Likes/Dislikes: \_\_\_\_\_

\_\_\_\_\_

Has the individual ever been the victim of abuse?      Yes                      No

Explain: \_\_\_\_\_

\_\_\_\_\_

Has this individual ever been charged with abuse or related misconduct?      Yes                      No

Explain: \_\_\_\_\_

Has this individual ever been known to harm themselves?      Yes                      No

Explain: \_\_\_\_\_

# Adventure Camp Retreat Agreement

I certify that the information provided on the application is true and accurate to the best of my knowledge. I assume full responsibility for all property belonging to \_\_\_\_\_. I will not hold Camp Calvary or any staff responsible for any damage to or loss of said property.

I request that Camp Calvary obtain necessary emergency medical treatment for the above-named camper as needed. I understand that I and/ or my medical insurance provider will be responsible for all medical costs incurred for such emergency medical care required during the Retreat sessions indicated.

Photographs or video recordings made of the above-named camper, during the camp sessions indicated, may appear in promotional presentations made by Camp Calvary.

**Please Note:** Based on the level of care required for the Camper and the staffing patterns of each Adventure Camp session, you may be required to provide a caretaker for the duration of the session.

**Please Note:** We must be able to contact the Parent/Guardian or caregiver for the camper named on this application at any time, day or night, for the duration of the retreat. If you, as the signer (below) will, at any time, be unable to respond to any communication regarding the camper, you MUST provide an alternate contact person for the retreat coordinator to call. That person must be able to contact you promptly.

**Refund Policy:** In the event that the camper cannot attend the retreat that they signed up for, the option of rescheduling the camper into another retreat is possible. If rescheduling is not feasible and it is more than 14 days from the retreat time, a refund of \$90 will be made. If the cancelation occurs within 14 days prior to the retreat, no refund will be made.

Signature Required:

\_\_\_\_\_

Parent/Guardian/Caregiver

\_\_\_\_\_

Date

\_\_\_\_\_

Camper

\_\_\_\_\_

Date

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In our efforts to meet the spiritual needs of campers, during the Adventure Camp sessions, we offer an opportunity for them to follow Christ's teachings to be immersed in baptism. Should this camper make this decision, we will follow your instructions as indicated below. If you have any questions about our belief regarding baptism by immersion, please call us. We welcome the opportunity to discuss this with you.

If \_\_\_\_\_ chooses to be baptized:

- \_\_\_\_\_ I authorize Camp Calvary to perform the baptism.
- \_\_\_\_\_ I prefer to have my minister perform the baptism at our home church.
- \_\_\_\_\_ I request to be present at the baptism.
- \_\_\_\_\_ Has already been immersed.
- \_\_\_\_\_ May not be baptized.

**Please mail the completed application and make checks payable to:**

**Camp Calvary  
475 Camp Calvary Lane  
Mackville, KY 40040**

**If you have any additional questions or concerns, please give us a call: 859-375-4376.**