



GENERAL INFORMATION

Camper Name _____ Age: _____ Birthdate: _____ Sex: M or F

Address _____ County: _____

City _____ State _____ Zip _____ Phone: _____

Does this person live with his/her parents? Yes No

If no, name of place of residence: _____ Phone: _____

Has this Camper attended SOS Camp before? Yes No If yes, what years: _____

EMERGENCY CONTACT INFORMATION

Who should be contacted in case of an emergency?

Name: _____ Relationship to Camper: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

PAYMENT (Please Complete all that Apply)

Total cost of S.O.S Camp: \$470.00

_____ (Insert Name or Organization) will be paying the **entire** fee for this camper.

OR

_____ will be paying _____ (insert amount) &
_____ will be paying the balance of _____.

PARENT/GUARDIAN CONSENT

I hereby give my permission for _____ to attend Shetek SOS Camp. Permission is given to use photographs and names of my son/daughter in camp promotions, including online. I understand precaution is taken to safeguard the health and safety of the campers under the supervision of Shetek Lutheran Ministries. I agree to relieve Shetek Lutheran Ministries and all personnel from any liability in connection with this activity.

Signature: _____ Date: _____

RETURN APPLICATION

In order to be considered registered and to hold a place for SOS Camp 2021, all forms (aside from the Physician's Form, which can be submitted at a later date) must be returned to Shetek Lutheran Ministries with a \$75.00 deposit. SOS camp fills quickly so register early to avoid being placed on a waiting list. Bring changes in behavior or medication with you to the camp registration on July 6, 2020OR fill out online.

Mail Application to: Shetek Lutheran Ministries/14 Keeley Island Dr./Slayton, MN 56172

For office use only:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Registration | <input type="checkbox"/> Personality History | <input type="checkbox"/> Deposit |
| <input type="checkbox"/> Consent | <input type="checkbox"/> Physician's Form | <input type="checkbox"/> Balance Paid |
| <input type="checkbox"/> Health History | <input type="checkbox"/> Medication Sheet | <input type="checkbox"/> _____ |

(Additional information to be completed on the back of this form)



Camper Name _____

INSURANCE INFORMATION Please provide a photocopy of the front and back of the camper's insurance card.

Family Physician: _____ Do you carry medical/hospital insurance? Yes No

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Insurance Company: _____ Policy or Group # _____

MEDICAL HISTORY

Current health conditions requiring medication, treatment or special considerations while at camp: _____

Please list approximate dates and explanation for all that apply.

- Diabetes Asthma Athlete's Foot Chicken Pox Mumps Blood Clotting Fainting Stomach Trouble Hernia
 Measles Hepatitis Respiratory Problems Heart Trouble Ear/Throat Trouble Bowel Trouble Menstruation Trouble

Please describe any health problems the camper has: _____

Does camper experience seizures? Yes No If yes, type: _____ Frequency: _____

Date of last seizure: _____ At what point do we call EMS for seizure related activity? _____

Does the camper have a Do Not Resuscitate (DNR) order: Yes No (If yes, please enclose copy order)

MEDICATIONS

This camper will not take any medications while attending camp. This camper will take the following medications while attending camp:
 (List medication name(s) here and transfer complete information i.e. name, dosage, times taken onto the enclosed **SLM Medication Sheet**.)

If medication, dosages, or times taken, changes after you've sent the *SLM Medication Sheet* to camp, bring an updated sheet with you on July 10, 2017. Please make copies of the sheet so you are prepared to bring these changes with you on the day you register at camp. This makes registration easier for the SLM Staff and less time consuming for you. Thank you for your cooperation!

Note: Any medication campers may be taking will be given to our camp health manager at registration. Be sure all medications are clearly labeled with: **1. Camper's Name 2. Name of Medication 3. Dosage 4. Time Medication is to be taken**

Also, supply the RX number and the name of the pharmacy supplying the medication. PLEASE SEND ENOUGH FOR THE WEEK PLUS ONE EXTRA. It is a good idea to send one extra dose of each medication as a replacement in the event that a medication is dropped/lost.

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

Acetaminophen (Tylenol)	Chloraseptic (Sore throat spray)	Calcium Carbonate Antacid (Tums)
Ibuprofen (Advil)	Bismuth subsalicylate (Pepto-Bismol)	Generic cough drops
Pseudoephedrine (Sudafed)	Laxatives for constipation (Ex-lax)	Calamine lotion
Destromethorphan (Cough Syrup)	Hydrocortisone 1% cream	Aloe
Diphenhydramine (Bendaryl)	Topical antibiotic cream	

Other Medical Concerns - Please provide 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 as needed.** _____

IN CASE OF MEDICAL EMERGENCY

If your camper is ill, he/she will be treated according to written and approved doctor's standing orders. Shetek Lutheran Ministries Staff will notify the parent and/or caregiver if your camper requires any type of advanced medical care beyond the basic care provided by the camp health staff. Shetek Lutheran Ministries will also contact you if there is a discrepancy between the dosage instructions on the label of a camper's medication and instructions received at registration. I give my permission to the local physician to hospitalize, treat, order injections, anesthesia or perform surgery if need be.

Signature: _____

Date: _____