



2008 Stepping Up! CAMPER Registration/Health Form



Please fill out completely and print clearly.

Participant and Parent/Guardian Information

Participant Name: _____
Last First Middle

Has the camper attended Camp Bob previously? Yes No

Gender: Male Female Birth date: ____/____/____

Guardian Name: _____

Address: _____

City, State, ZIP: _____
City State ZIP Code

Emergency Contact Name: _____

Sponsoring Organization: _____

Dates of Attendance: _____

Social Security No.: _____ - _____ - _____

Age (at time of attendance) _____

Home Phone: (____) _____ - _____

Work/Cell Phone: (____) _____ - _____

Phone Numbers: (____) _____ - _____

(____) _____ - _____

Medical Information

Does the participant take any medication? Yes (please describe below) No

Please list any medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep medications in their original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Does the participant have any allergies? Yes (please describe below) No

Does the participant have any medical history or restrictions that may limit participation or affect them while at camp?

Yes (please describe below) No

Parent/Guardian Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the president of Kanuga Conferences, Inc. or his designee to provide routine health care; to administer medications; order X-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or to arrange necessary related transportation for my child. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for my child. I give permission for photographs and/or audio/video recording of my child to be used by the camp for its promotion, web site and/or news media coverage. I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs sponsored by Kanuga Conferences, Inc. including but not limited to swimming, canoeing, climbing and ropes courses, which could result in accidental injury, possibly serious. Parents will be notified immediately if a problem is serious. Furthermore, engagement in these activities requires good physical condition on behalf of the participant. Being aware of the inherent risks and potential injury to my child, I hereby consent to my child's attendance and participation in the activities sponsored by Kanuga Conferences, Inc.

Signature of parent or guardian: _____ Date: ____/____/____

General Health Questions (Please explain "yes" answers below.)

| Has/does the participant: | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had joint problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Plan to bring an orthodontic appliance to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the last 12 months? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? ... | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? ... | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had sought professional help with emotional difficulties? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Ever been diagnosed with a heart murmur? . | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you marked yes to any of the above, please explain:

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Which of the following immunizations has the participant had?

- DTP Polio TD (tetanus/ diphtheria)
- MMR Measles Mumps
- Rubella Hepatitis B Varicella (chicken pox)
- Haemophilus influenza B

Date of last Tetanus shot _____

Health Care Information

Name of regular physician or health care facility _____ Phone (_____) _____ - _____

Is the participant covered by an insurance plan? Yes (please describe below) No

Plan Name: _____ Group Number: _____

Insurance Company address: _____

Name of insured/policy holder: _____ Relation to participant: _____

Policy ID number or Social Security number of policy holder: _____

Use this space to provide any additional information about the participant of which the camp should be aware: _____

Racial/Ethnic Identity

You are not required to answer these questions. If you choose to do so, please mark one of the following racial or ethnic identities:

- American Indian or Alaska Native Black or African American Hispanic or Latino
- Native Hawaiian or Other Pacific Islander Asian White

Please answer the following questions. This information is not required for your child to attend Camp Bob, but it allows us to participate in the Summer Food Service Program.

Camper's Name (First, Middle and Last): _____

1) Is this a foster child? Yes (please answer question below) No (please go to question 2)

What is the child's monthly personal use income? \$ _____. Skip questions 2 and 3 and go to #4.

In certain cases, foster children are eligible for free meals regardless of household income. If such children are living with you and you wish to apply for such meals, please contact us.

2) Are you getting Food Stamps, TANF or FDPIR benefits for your child? Yes No (please go to question 3)

If "yes," please list the case number and skip question 3 and go to 4.

Food Stamp Case number: _____

FDPIR Case number: _____

TANF Case number: _____

Children who are members of a household that receives food stamps, FDPIR or TANF benefits are automatically eligible to receive free meals in the program.

3) All other households: List all household members, including the child you are currently registering for camp. List all income.

| NAMES | CURRENT MONTHLY INCOME | | | |
|-------|--|---|---|---|
| | Monthly earnings from work (before deductions) Job 1 | Monthly Welfare, Child Support, Alimony | Monthly Payments from Pensions, Retirement, Social Security | Monthly Earnings from Job 2 or any other monthly income |
| 1. | \$ | \$ | \$ | \$ |
| 2. | \$ | \$ | \$ | \$ |
| 3. | \$ | \$ | \$ | \$ |
| 4. | \$ | \$ | \$ | \$ |
| 5. | \$ | \$ | \$ | \$ |
| 6. | \$ | \$ | \$ | \$ |
| 7. | \$ | \$ | \$ | \$ |
| 8. | \$ | \$ | \$ | \$ |
| 9. | \$ | \$ | \$ | \$ |
| 10. | \$ | \$ | \$ | \$ |

4) Signature and Social Security Number:

Penalties for Misrepresentation: The person signing this application certifies that all information provided is correct, that the household is applying for Federal benefits in the form of free Program meals, that Program officials may verify the information on the application and that purposely providing untrue or misleading statements may result in prosecution under State or Federal criminal laws. If food stamp, FDPIR or TANF case numbers are provided, they may be used to verify the current food stamp, FDPIR or TANF certification for the children for whom free meals benefits are claimed.

Signature of Parent/Guardian: _____ **Date:** _____

Social Security Number: ____ - ____ - _____ Check if guardian does not have a social security #

Unless you include your child's case number for the Food Stamp Program, the Food Distribution Program on Indian Reservations (or other identifier for the Food Distribution Program on Indian Reservations) or the Temporary Assistance for Needy Families Program, you must include the social security number of the adult household member signing this application or indicate that the household member does not have a social security number. This is required by section 9 of the National School Lunch Act. The social security number is not mandatory, but the application cannot be approved if a social security number is not given or an indication is not made that the signer does not have a social security number. The social security number will be used in the administration and enforcement of the program.

For Informational Purposes Only

Income to Report

Earnings from Work

Wages/ salaries/ tips
 Strike benefits
 Unemployment compensation
 Worker's compensation
 Net income from self-owned
 business, day care business,
 or farm

Pensions/ Retirement/ Social Security

Pensions
 Supplemental Security Income
 Retirement Income
 Veteran's payments
 Social Security

Other Monthly Income/ Self-Employment

Disability benefits
 Cash withdrawn from savings
 Interest/ dividends
 Income from estates/ trusts/ investments
 Regular contributions from persons not living
 in the household
 Net Royalties/ annuities/ net rental income
 Military allowance for off-base housing
 Any other income

Welfare/ Child Support/ Alimony

Public assistance payments
 Welfare payments
 Alimony/ child support payments

The following Household Size and Income Standards are used to determine eligibility:

Effective July 1, 2002 – June 30, 2003

SFSP Income Eligibility Standards

| Household Size | Yearly Reduced | Monthly Reduced | Weekly Reduced |
|--------------------|----------------|-----------------|----------------|
| 1 | 16,613 | 1,385 | 320 |
| 2 | 22,422 | 1,869 | 432 |
| 3 | 28,231 | 2,353 | 543 |
| 4 | 34,040 | 2,837 | 655 |
| 5 | 39,849 | 3,321 | 767 |
| 6 | 45,658 | 3,805 | 879 |
| 7 | 51,467 | 4,289 | 990 |
| 8 | 57,276 | 4,773 | 1,102 |
| For each Household | | | |
| Member add: | +5,809 | +485 | +112 |

Households with incomes less than or equal to these outlined values qualify for free SFSP meals.

For institution to be classified and completed by institution/sponsor

For official use only:

Food Stamp/FDPIR/TANF household categorically eligible free: Yes No

Foster Child categorically eligible free: Yes No

Household Size: _____ Total Yearly Income: _____ or Monthly Income: _____ or Weekly Income: _____

Eligible

Not Eligible

Determining Staff: _____ (Initial)