



# North East Worship Camp

July 8<sup>th</sup>-13<sup>th</sup>

## Return these forms by **June 27<sup>th</sup>** to:

New Hope Fellowship, ATTN: NEWC  
PO Box 96, East Bloomfield, NY 14443

E-mail: [neworshipcamp@gmail.com](mailto:neworshipcamp@gmail.com)

## Registration & Camp Information:

- Your teen is not fully registered until we receive these completed forms in our office.
- **NEWC is an unplugged camp.**
  - Personal cell phone use will be allowed during our daily designated times.
  - Phones will be kept in the possession of counselors during regular camp functions.
- **Note:** NEWC does not take any financial responsibility for items lost or stolen while attending North East Worship Camp.

## Medical Information Packet Checklist:

We are only able to process **complete** forms; please be sure all of the following components are complete:

### Commitment and Agreement

- Teen has initialed each blank and signed and dated at the bottom
- Parent has initialed each blank and signed and dated at the bottom

### Health Form Information

- Allergies and scheduled medications provided
- Parent / legal guardian section of the health form completed and signed
- Physician section of the health form completed and signed
- Teen's immunization record provided

## Medication Guidelines:

### Before Camp:

- Written medication orders, **signed by your Physician**, must be mailed to camp at least one week before the camp week starts.
- Please check expiration dates on all medications.

### At Registration:

- All medications must be delivered to the camp nurse by a parent or designated representative. Please place ALL medication (prescription or over-the-counter) in a clear zip lock bag with your teen's first and last name, date of birth, and if the medication is "scheduled" or "as needed" so it can be clearly seen and read.
- All medications must be in the original container (even OTC medications) with the pharmacy label securely attached. Please supply enough pills to last while your teen is at camp plus an extra two days.
- *Unlabeled medication or preparations will not be accepted.*
- Any corrections to the orders (i.e. dosage changes or additional/discontinued medicines) must have written verification from your Physician.

### During Camp:

- Only nursing staff will administer medications to all campers.
- Medications will be kept in a locked cabinet at the Nurses' Station.

### End of Camp:

- Nursing staff will return all medication to the parent or designated representative.

Teen's Name \_\_\_\_\_

**Medical Information Packet: Commitment & Agreement – Page 1**

Please acknowledge your agreement with the following statements by **initialing** each of the lines and signing your name:

**Teen Commitment:**

\_\_\_\_ **I commit** to follow and adhere to all NEWC guidelines, the Camp Staff and Counselors, as well as all standards of Christ-like behavior.

\_\_\_\_ **I commit** to wear modest and appropriate dress. I understand that NEWC Staff may deem certain clothing inappropriate, and I will adhere to their decisions.

\_\_\_\_ **I commit** to not physically or emotionally date anyone while at NEWC. I understand my emotions and affections must be on Jesus for maximum impact.

\_\_\_\_ **I commit** to an "unplugged" camp experience. I commit to abide by the camp rules that do not permit the use of cell phones and other electronics.

\_\_\_\_ **I commit** to abide by camp rules for the use of cell phones only during designated times.

\_\_\_\_ **I commit** to not bring drugs, alcohol, tobacco, firearms, fireworks, airsoft/paintball guns, weapons, suggestive clothing, inappropriate magazines, or any questionable materials.

\_\_\_\_ **I commit** to participate fully in the activities and electives of the event in which I register.

\_\_\_\_ **I commit** to follow the safety regulations and the direction of the staff.

\_\_\_\_ **I consent** to the search of all my luggage, backpack, purse, etc.

**Parent Agreement:**

\_\_\_\_ **I agree** that I have read and discussed the Teen Commitment with my teen and commit to support my teen during his or her camp experience at NEWC.

\_\_\_\_ **I agree** that to the best of my knowledge and belief that the facts I have provided to support my application are true, correct, and complete.

\_\_\_\_ **I agree** to support my teen in their "unplugged" camp experience by not sending them to camp with any iPods, laptops, or any entertainment devices. I understand that they will only have access to their mobile phones during designated times each day.

\_\_\_\_ **I give full permission** for my teen to attend the event for which he/she has registered.

\_\_\_\_ **I give full permission** for my teen to participate in all activities and electives unless otherwise noted on health form.

\_\_\_\_ **I consent** to the search of all my teen's luggage, backpack, purse, etc.

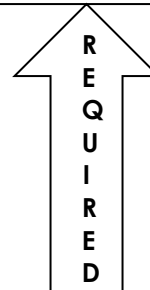
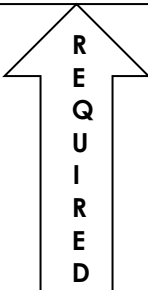
\_\_\_\_ **I give full permission** for my teen's image and voice to be used in publicity photos, films and video. (No last names or personal info will be used.) The undersigned releases and forever discharges North East Worship Camp, *their agents, officers and employees from any and all claims and demands arising out of or in connection with the publication or any other use of said photos/videos/images, including but not limited to, any claims for invasion of privacy or defamation.*

\_\_\_\_\_  
**Teen Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**



Teen's Name \_\_\_\_\_

**Medical Information Packet: Health Form Information – Page 2**

**Parent / Legal Guardian: Please complete the following questions**

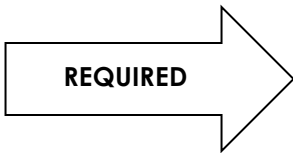
Has teen had any recent illness or injury? If so, what and when? \_\_\_\_\_

Does teen have any special challenges (e.g. ADHD, behavior disorders, physical/mental conditions, special diet needs)? If so, list below and call our office to verify if we can accommodate your teen's needs.

Is your teen under medical care or have a history of any medical conditions? (i.e. asthma, diabetes, seizures)

**Health Insurance Information:**

Carrier \_\_\_\_\_ Type \_\_\_\_\_  
Policy # \_\_\_\_\_ In Whose Name? \_\_\_\_\_



**Over-the-Counter Medication Authorization**

Please provide written consent for common over-the-counter (OTC) medicines to be given to your teen based on the labeled dosing and weight of your child as deemed necessary by NEWC personnel.

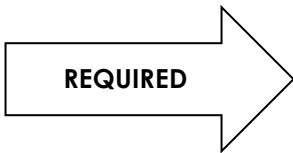
- YES, I approve of NEWC personnel providing common OTC's to my child as needed.
- NO, I do NOT approve of NEWC personnel providing my child OTC's without my verbal consent for which I am providing a number where I can be reached easily.

If you answered NO, please provide two telephone numbers below.

1. ( ) \_\_\_\_\_ 2. ( ) \_\_\_\_\_

\_\_\_\_\_  
**Parent / Legal Guardian Signature**

\_\_\_\_\_  
**Date**



**Authorization to Consent to Medical Treatment/Activities Consent**

As the parent or legal guardian of the above named teen, I hereby authorize North East Worship Camp to consent to any and all medical, dental, or other health-related treatment on behalf of the above named teen, and to admit the teen to any hospital, clinic, or other health care institution, or to consent to his or her evaluation or treatment by an licensed health care practitioner, the said NEWC staff, to have, by virtue of these premises, the same rights, privileges and authority with respect to the teen as I possess and could exercise were I present, to the extent aforesaid. I will not hold NEWC or its staff responsible for any injuries or damages related to obtaining or consenting to such medical treatment. I also give permission for the teen to participate in activities with restrictions as indicated in the Health Form Information. I declare that the health information I have provided in this application, to the best of my knowledge and belief, is true, correct, and complete.

\_\_\_\_\_  
**Parent / Legal Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Day Phone**

Teen's Name \_\_\_\_\_

**Medical Information Packet: Health Form Information cont'd – Page 3**

**Physician: Please complete and sign below**

Teen's date of birth: _____ Weight: _____ kg/lbs Date of last physical: _____ / _____ <div style="text-align: center; font-size: small;">                     _____                      Month                      Year                 </div>	<input type="checkbox"/> List Camper Allergies _____ _____ _____
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Medication	Dosage	Route	Frequency	Times to be given (8a/12n/5p/HS)
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				

OTC Med's Available at Camp	Dosage	Indications	MD Approval
1. Antacid Tablets (>12 yo) (Desatrose/fructose/phosphoric acid)	as directed on label	for minor heartburn	Yes/No
2. Bacitracin Ointment	as directed on label	for minor burns/wounds	Yes/No
3. Benadryl 25 mg	as directed on label	for minor skin reactions/allergies	Yes/No
4. Benzocaine 20% (Orajel)	as directed on label	for toothache & canker sores	Yes/No
5. Caladryl	as directed on label	for minor skin reaction	Yes/No
6. Chloraseptic spray	as directed on label	for minor sore throat	Yes/No
7. Hydrocortisone cream 1%	as directed on label	for minor skin itching/reaction	Yes/No
8. Ibuprofen (10mg/kg/dose)	as directed on label	for minor aches and pains	Yes/No
9. Loperamide Hydrochloride 2mg	as directed on label	for uncomplicated diarrhea	Yes/No
10. Loratadine 10 mg	as directed on label	for minor allergies	Yes/No
11. PeptoBismol (20mg/kg/dose)	as directed on label	for uncomplicated diarrhea	Yes/No
12. Phosphorated Carbohydrate Sol'n (Anti-emetic)	as directed on label	for nausea	Yes/No
13. Guaifenesin 100mg/5ml	as directed on label	for chest congestion	Yes/No
14. Sunscreen UVA/UVB	as directed on label	for skin protection of the sun	Yes/No
15. Tolnaftate Cream 1%	as directed on label	for fungal infections	Yes/No
16. Triple Antibiotic Ointment (Bacitracin/Neomycin/Polymyxin B)	as directed on label	for minor wounds	Yes/No
17. Tylenol (15 mg/kg/dose)	as directed on label	for minor aches and pains	Yes/No

**\*Please attach a current copy of Teen's Immunization Record**

Physician Signature: \_\_\_\_\_ Print: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

