**A close up of a logo

Description automatically generatedREGISTRATION FORM - PLEASE PRINT:**

Camper’s Name

Age Grade Completed, Spring 2024

Birthdate: □Male □Female T-shirt size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

City Zip

Parent/Guardian Name

Phone ( )

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Church

City

Please return these forms electronically or by mail to Emmanuel Lutheran Church, Summer Day Camp, 790 Tamiami Trail S, Venice, FL 34285.

SIGNED: DATE:

**PERMISSION SLIP**

I, , hereby give permission for my child/children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(parent or guardian)

to leave the Emmanuel Lutheran Church campus/grounds with camp counselors on the following

planned field trips during the week of Day Camp, July 8-12, 2024.

List of specific locations.

Chuck Reiter Field

250 Fort Street

Venice, FL 34285

SIGNATURE OF CUSTODIAL PARENT/GUARDIAN\* DATE

**PHOTOGRAPH PERMISSION**

I hereby allow my child to be photographed for possible inclusion in Emmanuel

Lutheran Church and Luther Springs/NovusWay publications, website and social media.

SIGNATURE OF CUSTODIAL PARENT/GUARDIAN\* DATE

**\*Signature of Custodial Parent or Guardian Required**

**DAY CAMP HEALTH HISTORY FORM**

This Day Camp is a partnership between Luther Springs and your local congregation (above). We want to provide your child with the best possible week at camp including spiritual, physical, and social growth. You can help by carefully filling out this form. Health forms must be turned into the Day Camp coordinator no later than the first morning of the Day Camp. **Each camper must have a completed health form on file or WILL NOT be admitted to Day Camp.**

**PLEASE PRINT**

Full Name of Camper

Last First MI

Age

Birth date

 Male  Female

Camper's Address City State Zip Name (s) of Parent (s) or Guardian Home Phone ( ) Work Phone ( ) Cell Phone ( )

If I cannot be reached in an emergency call: \_

Relationship: Home Phone ( )

Work Phone ( ) Cell Phone ( )

Name of Child's Physician: Phone ( )

**Health Insurance Information:**

LUTHER SPRINGS and the local congregation have secondary accident insurance. The parent/legal guardian is responsible for all charges associated with an accident or illness.

Carrier name Carrier Address Policy # Phone Policy Holder’s Name Policy Holder’s Social Security # Policy Holder’s Birthdate

**Medical Release and Authorization For Treatment**

This day camp is a partnership between Luther Springs Lutheran Outdoor Ministries (LUTHER SPRINGS) and the local congregation listed above. The undersigned, as parent/legal guardian of the camper, authorizes LUTHER SPRINGS and the local congregation, its delegated leaders, directors, and medical personnel they have selected to consent to any medical/hospital care deemed necessary. I consent to the release of this health history and examination form to the emergency room, hospital, or doctor’s office providing care. Day Camp leaders will endeavor, but are not required, to communicate with me prior to treatment. The undersigned releases LUTHER SPRINGS and the local congregation, and its designated leaders and directors from any liability and claims arising from any consent given in good faith in connections with diagnosis or treatment. The undersigned certifies that he/she has full authority to sign this Release and Authorization. This completed form may be photocopied for trips off site.

Printed Name:

Signature:

Date:

**CAMPER HEALTH HISTORY CONTINUED**

Describe any current physical, mental or psychological health conditions requiring medication, treatment, or special restrictions or considerations while at camp:

Activities from which the camper should be exempted for health or other reasons:

Does camper know how to swim? Yes No Somewhat

**Allergies:** Please list any allergies (food, medicine, insect stings, etc.):

**Asthma:**  Severe Moderate  Mild Triggers?

**Nutritional/dietary restrictions:**

Diabetic? No Yes Vegetarian? No Yes

**Camper Medications:**

A first-aid kit will be present at all times and contains the following medications: Tylenol, Motrin, Cold Medication and Antacids/Antidiarrheals. **May your child receive these medications if needed?**

Yes No Comments:

IF YOUR CHILD NEEDS TO BRING ANY MEDICATION TO BE TAKEN DURING DAY CAMP

HOURS PLEASE FILL OUT THE INFORMATION BELOW. All medications (including aspirin, vitamins) must be checked in with the local coordinator upon arrival.

I give my permission for the Local Coordinator or designated church volunteer to keep and administer the following medications:

Name of Med. Dosage How often Name of Med. Dosage How often

Any special information concerning this medication?

\_

Signed Date

Parent or Guardian Name

**Personal Information**: Please share any information that will help us give your camper the best experience possible.

Has anything happened recently in your family or with friends that may affect your child's behavior while at camp? Any emotional upsets?

Is your child apprehensive about anything at camp?

Any other suggestions or special information for the counselor?