



# Service Retreat

March 23-25

Spend a weekend serving God and growing in your faith. The cost is \$40 per person before March 16. The late fee is \$30.

Open to middle school and high school students and their youth leaders

Pack for work but also pack for fun. Youth groups are welcome and encouraged. One youth leader for every six youth comes free. Email [rich.dugan@delanco.org](mailto:rich.dugan@delanco.org) with questions.

# Service Retreat Registration form

Full Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Age \_\_\_\_\_

Email \_\_\_\_\_

Church \_\_\_\_\_

Is your leader attending this weekend? \_\_\_\_ Yes \_\_\_\_ No

If yes, who? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

If you are between the ages of 16 and 18 and want to use power tools  
(no chainsaws), please provide parent signature.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Mail this form along with health history form to:  
Delanco Camp, 191 Powell Place Road, Tabernacle NJ 08088

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below by \_\_\_\_\_ (date)

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

**To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. *(Please describe below.)*

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

*Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.*

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

*If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Camper Name \_\_\_\_\_  
 First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 (For Camp Use) Cabin or Group \_\_\_\_\_  
 (For Camp Use) Session Code(s): \_\_\_\_\_



# CAMPER HEALTH HISTORY FORM 1

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Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain "Yes" answers in the space below,** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** 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 if needed.**

**Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.**

