



## 2020 JR. High Fall Retreat Information Form

Participant's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female

Parent/Guardian \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Email Address \_\_\_\_\_

In case of EMERGENCY the following person could be notified:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Your child will be required to check out with YMCA staff. In addition to above listed parents, ONLY those listed below will be allowed to sign out participant. If for some reason someone other than those listed need to pick your child up we will need either written permission from the custodial parent/guardian or you may contact the Camp Director to make those arrangements.

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Is there anyone NOT allowed to pick participant up? \_\_\_\_\_

MEDICAL Information:

Participant's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Medications : \_\_\_\_\_

Last Tetanus Immunization: \_\_\_\_\_

Food/Other allergies \_\_\_\_\_

INSURANCE Information:

Is the camper covered by family medical/hospital insurance?  Yes  No

Medical Insurance Carrier or plan name \_\_\_\_\_ Policy ID \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to camper \_\_\_\_\_



This info sheet MUST be filled out when registering your child for Jr. High Fall Retreat.

**TRANSPORTATION/PICK-UP**

My child has permission to ride the Y bus to and from JR. High Fall Retreat:     Yes     No

**PERMISSION TO ADMINISTER MEDICATION**

Complete this information if your child will be needing medication while at YMCA administered activities. Please bring the medication in the original pharmacy container.

**Medication:**

\_\_\_\_\_ Dose \_\_\_\_\_

Days/dates to be given \_\_\_\_\_

Circle time to be given:    Breakfast    Lunch    Dinner    Bedtime    Other \_\_\_\_\_

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\_\_\_\_\_ Dose \_\_\_\_\_

Days/dates to be given \_\_\_\_\_

Circle time to be given:    Breakfast    Lunch    Dinner    Bedtime    Other \_\_\_\_\_

**ALLERGIES**

Medication allergies (list) \_\_\_\_\_

Food allergies (list) \_\_\_\_\_

Please visit with camp directors prior to your child arriving to camp if there are specific food allergies; lactose intolerance, gluten-free. This will allow us the opportunity to prepare meals accordingly.

Other allergies (list) include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_  
\_\_\_\_\_

I understand that there are inherent risks involved with Fall Retreat. However, in case of medical emergency, I understand that every effort will be made to contact the parents/guardians of the camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and order medical attention for my child.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

I give permission and consent to allow photographs of my child (above) to be taken during YMCA JR. High activities. I further give permission and consent that any such photographs may be published and used by the Sheridan County YMCA.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_