Older Adult Retreat September 18 - 20, 2018

Registration

16170 Manastash Road Ellensburg, WA 98926 lazyfcamp.org
Office: (509) 962-2780 Fax: (509) 962-6414 office@lazyfcamp.org

Participant Information

Name:_____ Preferred Name:_____
Mailing Address:_____ City_____
State_____ Zip_____ E-mail: _____
Phone(s): _____ Church, if any:_____
Birthdate: _____ Gender: _____

Emergency Contact

Name: _____ Relationship to camper: _____
Phone(s): _____ E-mail: _____

Insurance Information

Carrier or Plan Name:_____ Group #:_____ Name of Insured: _____
Carrier's Address:_____ Relationship: _____
Policy holder's social security number or insurance ID number: _____

Covenant

I agree to take part in all camp activities unless limitations are noted on attached Participant Registration and Health History Form, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I recognize and acknowledge that camping activity can involve certain hazards, including, but not limited to, illness, injury, and accidents, and release The United Methodist Church from liability.

I GIVE PERMISSION FOR:

- Photocopying of health history form
- Photos/video to be used in future publicity
- Participant's name, and e-mail address to be included in an address list

Participant's signature:_____ Date:_____

Prices:

$155 if postmarked by April 1, 2018 (early bird special)
$175 if postmarked after April 1, 2018
add $15.00 per person for Skyline. Double occupancy required if the need arises: invite someone you would like to room with!

Return this form, Health History Form, and $35.00 deposit to the address above. Full payment is due September 1. Cancellations occurring before September 1 will be refunded minus the non refundable, non transferrable deposit. The full amount is due for cancellations occurring after September 1. At this point, preparations have been made to host the person registered. Policy exemptions will be considered on an individual basis. If the event is cancelled, you will receive a full refund including the deposit. "No Shows" will not receive a refund.

You're not finished yet!

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Health History Form

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Please fill out both pages of the Health History Form.

Participant's Name:_____

Allergies: List all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Describe reaction and management of the reaction.

ALLERGIES	REACTION AND MANAGEMENT
_____	_____
_____	_____

Epi Pen? ___ Yes ___ No

MEDICATION: Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Please bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications must be checked in to camp staff upon arrival.**

☐ Check this box if **NO medications** on a routine basis.

Medication taken as follows (attach additional pages for more medications, if necessary)**:**

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:_____

Identify any medications taken that the camper does not/may not take during this weekend. _____
_____

Health History

Please check any that have applied in the last 3 years, and explain on a separate sheet.

- □ Alcohol / drug addiction
- □ Allergic reaction – severe
- □ Anxiety / depression
- □ Asthma
- □ ADD / ADHD
- □ Back pain / strain
- □ Broken bones
- □ Diabetes, type 1
- □ Diabetes, type 2
- □ Ear infections (frequent)
- □ Eating disorders
- □ Epilepsy or seizures
- □ Eyeglasses or contacts
- □ Headaches
- □ Hearing aids
- □ Heart disease/surgery
- □ Infections
- □ Menstrual problems
- □ Nightmares
- □ Sleepwalking
- □ Sore throats - frequent
- □ Tobacco usage
- □ Other: _____
- □ Medical treatment (please explain on separate sheet)

You're not finished yet!

Please continue to Page 2 of the Health History Form.

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Participant's Name:_____

SPECIAL NEEDS and RESTRICTIONS

Explain any restrictions to camp activities (e.g. what cannot be done, what adaptations or limitations are necessary) and provide any information that will enable us to create a healthy, helpful environment for the camper. Please include: recent injuries or illnesses, medical conditions requiring treatment (i.e. surgery, overnight hospital stays, ongoing conditions, etc.), behavioral/learning challenges and suggested disciplines, emotional needs/concerns, hearing impairments, visual impairments, bedtime habits and any special routines, etc.).

_____

_____

_____

Please list any **dietary** restrictions (other than allergies listed above) with explanation:

_____

Tetanus ☐ Current Date:_____

Immunizations ☐ Current Date:_____

STATEMENT

In case of medical emergency, I understand that every effort will be made to notify the Emergency Contact person named on Page 1 of the accompanying Participant Registration Form. I hereby give permission to the event coordinators to provide routine health care, administer prescribed medications, administer non-prescription (over-the-counter) medicines as necessary in the judgment of the health care provider or designee, and seek emergency medical treatment including ordering x-rays or routine tests. In the event that the person cannot be reached, I give permission to the leadership of Lazy Daze, including the staff and volunteers, to notify a physician, and I give permission to that physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for participant named above.

The information furnished in this Health History Form is correct and complete as far as I know. The participant herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for insurance purposes. I also agree that this completed form may be photocopied by Lazy F.

Signed, _____ Name (print): _____ Date:_____

Be sure to complete page 1 of the Health History Form.