Partnering Organization_____ City/State _____

Director's Name_____ Email_____Phone #_____

Adventure Week @ Camp Rockmont

202___

Chaperone Registration Form

(complete this form and return to your Partnering Organization to be eligible)

PLEASE PRINT

Chaperone's Name _____ / _____ / _____
(first) (middle) (last)

Chaperone SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ____ Date of Birth ___ ___/___ ___/___ ___ Age _____

Chaperone's Address _____

City _____ State_____ Zip _____

Chaperone's Home Phone #_____ Cell Phone #_____

Emergency Contact Name _____Phone #_____

Do you know how to swim? Yes_____(describe ability below) No_____

_____

Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the Director of Camp Rockmont or his designee to provide routine health care; to administer medications; order x-rays, routine tests & treatment; to release any records necessary for insurance purposes; or to provide or to arrange necessary related transportation for my child. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for myself. I give permission for photographs and/or audio/video recording of myself to be used by the camp for its promotion, website and/or news media coverage. I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs offered during *Adventure Week* including but not limited to swimming, canoeing, climbing, target sports, and adventure elements, which could result in accidental injury, possibly serious. Your Emergency Contact will be notified immediately if a serious incident occurs. Furthermore, participation in these activities requires good physical condition by the participant and so I am aware of the inherent risks and potential for injury to myself.

Signature _____ Date:___ ___/___ ___/___ ___

We are excited to have you join in this important camp experience. We appreciate your commitment to the boys in our care for the week. The questions below will help us determine how and where to best use your skills and talents. There will be a brief orientation upon your arrival to help integrate you into the camp community and program.

How long have you worked with this sponsoring organization? Please describe your work: _____

_____

_____

_____

_____

_____

Have you worked with other youth organizations? If yes, please list their names and a brief description of your work with them: _____

_____

_____

_____

_____

_____

What is your occupation? If a student, where are you in school and what are you studying? _____

_____

_____

_____

_____

_____

Please describe below your talents and skills and what you hope to achieve during your time at camp:_____

_____

_____

_____

_____

_____

Rockmont is a tobacco-free and drug-free environment, and the use of tobacco products or illegal drugs is prohibited on camp property or any camp-sponsored trip. Chaperones agree to abstain from tobacco entirely during their time at camp whether on or off camp. Are you willing and able to abide by this policy? ❑ Yes ❑ No

Rockmont is an alcohol-free environment, and the use of alcohol products is prohibited on camp property or any camp-sponsored trip. Chaperones agree to abstain from alcohol entirely during their term of employment, whether on or off camp. Are you willing and able to abide by this policy? ❑ Yes ❑ No

Do you have an visible tattoos or body piercings? ❑ Yes ❑ No

Have you ever been charged or convicted of a felony or misdemeanor? ❑ Yes ❑ No

Have you ever been charged with DUI (Driving Under the Influence of alcohol) or DWI (Driving While Impaired)? ❑ Yes ❑ No

I understand that a background check may be conducted. ❑ Yes ❑ No

Medical Information (Must be filled out completely to be eligible for camp.)

Does the chaperone have any allergies? ❑ Yes (please describe below) ❑ No

_____

Does the chaperone take any medications? ❑ Yes (please describe below) ❑ No

Please list any medications (including over the counter or non-prescription drugs) taken regularly. Bring enough medications to last the entire time at camp. Keep medications in their original bottle/package that identifies the prescribing physician (if prescription), the name of he medication, the dosage, and frequency of administration.

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 _____

General Health Questions (Please explain "yes" answers below.)

HAS/DOES THE PARTICIPANT:	Yes	No
1. Had any recent injury, illness or infectious disease	❑	❑
2. Have a chronic or recurring illness/condition?	❑	❑
3. Ever been hospitalized?	❑	❑
4. Ever had surgery?	❑	❑
5. Have frequent headaches?	❑	❑
6. Ever had a head injury?	❑	❑
7. Ever been knocked unconscious?	❑	❑
8. Wear glasses, contacts or eyewear?	❑	❑
9. Ever had frequent ear infections?	❑	❑
10. Ever passed out during or after exercise?	❑	❑
11. Ever been dizzy during or after exercise?	❑	❑
12. Ever had seizures?	❑	❑
13 Ever had chest pain during or after exercise?	❑	❑
14. Ever had high blood pressure?	❑	❑
15. Ever been diagnosed with a heart murmur?	❑	❑
16. Ever had back problems?	❑	❑
17. Ever had joint problems?	❑	❑
18. Plan to bring an orthodontic appliance to camp?	❑	❑
19. Have any skin problems?	❑	❑
20. Have diabetes?	❑	❑
21. Have asthma?	❑	❑
22. Had mononucleosis in the last 12 months?	❑	❑
23. Had problems with diarrhea/constipation?	❑	❑
24. Have problems with sleepwalking?	❑	❑
25. Have a history of bed-wetting?	❑	❑
26. Ever had an eating disorder?	❑	❑
27. Ever had sought professional help with emotional difficulties?	❑	❑

If you marked yes to any of the above, please explain:_____

_____

_____

(continued on next page)

Which of the following has the participant had?

❑ Measles ❑ Hepatitis A
❑ Chicken Pox ❑ Hepatitis B
❑ German Measles ❑ Hepatitis C
❑ Mumps

Which of the following immunizations has the participant had?

❑ DTP ❑ Polio ❑ TD (tetanus/diptheria)
❑ MMR ❑ Measles ❑ Mumps
❑ Rubella ❑ Hepatitis B ❑ Varicella (chicken pox)
❑ Haemophilus influenza B

Date of last Tetanus shot_____

Health Care Information

Name of regular or health care facility_____Phone (_____) ___ ___ ___-___ ___ ___ ___

Is the participant covered by an insurance plan? ❑ Yes (please describe below) ❑ No

Plan Name: _____ Group Number:_____

Insurance Company address: _____

Name of insured/policy holder: _____ Relation to participant: _____

Policy ID number of Social Security number of policy holder: _____

Use this space to provide any additional information about the participant of which the camp should be aware: _____

_____

_____

_____

_____

**** Please provide a copy of health insurance and prescription drug card.***