CAMP FRONTIER
P.O. BOX 2555, Riverview, FL 33568 1-888-977-2267
CampFrontier.com Administrator@CampFrontier.com

Emergency Contact, Medical History, Enrollment Agreement

(To be completed only by the Camper's parent of legal guardian)

Camper Information:

Last Name_____First Name_____Middle Name_____

☐ Boy ☐ Girl Date of Birth ___/___/___ (Month/Day/Year) Age upon arrival_____ Grade Entering_____

Social Security #_____

Parent/ Guardian Information:

Parent/ Guardian Name(s)_____

Home Address_____City_____State_____Zip_____

Child resides with (check all that apply): ☐Parents ☐Father ☐Mother ☐Step-Father ☐Step Mother

☐Other _____

Father: Home Telephone # (____)_____ Cell (____)_____ Email_____

Mother: Home Telephone # (____)_____ Cell (____)_____ Email_____

EMERGENCY CONTACTS (Please list three persons other than the above)

#1: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

#2: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

#3: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

Any Comments concerning emergency contacts:_____

Camper's Doctor or Clinic: _____Telephone (_____)_____

Is the camper covered by Medical Insurance? ☐Yes ☐No

Insurance Company:_____ Insurance Company Phone #: (_____)_____

Name of Subscriber:_____ ID or Policy #_____

Coverage Effective Date:___/___/___ Additional Information: _____

Important: Please provide a copy of the insurance card, front and back.

Camper's Last Name _____ First Name _____Middle _____

Date of Birth _____/_____/_____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Please explain all "Yes" answers below.

Has/does the camper:

1. Ever required Hospitalization? ---------- ☐Yes ☐No
2. Ever had surgery? ---------- ☐Yes ☐No
3. Have frequent ear infections? ---------- ☐Yes ☐No
4. Had a recent infectious disease? ---------- ☐Yes ☐No
5. Have Heart Defect/ Disease? ---------- ☐Yes ☐No
6. Have Convulsions/ Seizures? ---------- ☐Yes ☐No
7. Have diabetes? ---------- ☐Yes ☐No
8. Have bleeding/ clotting issues? ---------- ☐Yes ☐No
9. Ever had high blood pressure? ---------- ☐Yes ☐No
10. Wear Glasses, contact, or protective eyewear? ---- ☐Yes ☐No
11. Ever had Psychiatric Treatment? ---------- ☐Yes ☐No
12. Have a disability? ---------- ☐Yes ☐No
13. Have a chronic or recurring illness? ---------- ☐Yes ☐No
14. Have allergies and allergic conditions? ---------- ☐Yes ☐No
15. Have any food or beverage allergies? ---------- ☐Yes ☐No
    Vegetarian, Lactose Intolerant, Gluten Intolerant, etc.
16. Have any food or beverage restrictions---------- ☐Yes ☐No
17. Have issues with bed wetting? ---------- ☐Yes ☐No
18. Ever had Strep Throat? ---------- ☐Yes ☐No
19. Ever had Lead Poisoning? ---------- ☐Yes ☐No
20. Ever had mononucleosis (mono)? ---------- ☐Yes ☐No
21. Ever had sickle cell? ---------- ☐Yes ☐No
22. Ever had a Head/ Neck Trauma/ Injury? ---------- ☐Yes ☐No
23. Ever broken a bone? ---------- ☐Yes ☐No
24. Ever had chicken pox? ---------- ☐Yes ☐No
25. Ever had measles? ---------- ☐Yes ☐No
26. Ever had mumps? ---------- ☐Yes ☐No
27. Ever had MRSA? ---------- ☐Yes ☐No
28. Have braces or retainers? ---------- ☐Yes ☐No

For Females: ☐Yes ☐No

29. Is the camper menstruating? ---------- ☐Yes ☐No
    Are cycles normal? ---------- ☐Yes ☐No
30. If no, is camper presently using prescription medication for regularity? ---------- ☐Yes ☐No

Please explain "Yes" answers in the space below, including the number of the questions. Please provide the approximate dates.

Medical History

For campers with special medical needs such as Epilepsy, Insulin-Dependent Diabetes, Cancer or any physically disabling condition requiring a wheel chair – please contact the Camp Office at 1-888-977-2267 prior to continuing with this form.

The following non-prescription medications are used by the camp Health Center to manage any illnesses. Please check the follow;

I give my permission:

Ibuprofen (Advil, Motrin) ---------- ☐Yes ☐No
Acetaminophen (Tylenol) ---------- ☐Yes ☐No
Pseudoephedrine decongestant (Sudafed) ---------- ☐Yes ☐No
Phenylephrine Decongestant (Sudafed PE) ---------- ☐Yes ☐No
Antihistamine/ Allergy Medication ---------- ☐Yes ☐No
Diphenhydramine Antihistamine (Benadryl) --------- ☐Yes ☐No
Guaifenesin Cough Syrup (Robitussin) ---------- ☐Yes ☐No
Bismuth subsalicylate for diarrhea (Imodium) ------ ☐Yes ☐No
Dextromethorphan Cough Syrup (Robitussin DM) ---------- ☐Yes ☐No
Sore Throat Spray ---------- ☐Yes ☐No
Cough Drops ---------- ☐Yes ☐No
Lice Shampoo or cream (Nix) ---------- ☐Yes ☐No
Laxatives (Natural, Vegetable) ---------- ☐Yes ☐No
Analgesic Cream ---------- ☐Yes ☐No
Antibiotic Cream ---------- ☐Yes ☐No

Please list any camp activities or programs in which the camper may <u>not</u> participate:

_____

_____

Camper's Last Name _____ First Name _____Middle _____

Date of Birth _____/_____/_____
Month/Day/Year

Immunization Records:

If your camper has not been fully immunized, please sign the following statement:

I request that _____be exempted from the immunization required for attendance at Camp Frontier.
Name of Camper

I understand and accept all of the risks for my child from not being fully immunized.

Signature of Parent/ Guardian: _____ **Date**: _____

Immunization History: Please provide the month and year for each of the immunizations listed. A copy of your camper's immunization form provided by your health care provider or local government, or a religious exemption form are also acceptable. If you choose to supply those documents, please attach copies to this form.

Immunization	Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month/ Year
Diphtheria, tetanus, pertussis *DTap or TdaP*					
Polio *IPV*					
Haemophilus influenza type B *HIB*					
Pneumococcal *PCV*					
Hepatitis B					
Mumps, measles, rubella *MMR*					
Varicella *Chicken Pox*					
☐Had Chicken Pox	Date:				
Tetanus Most Recent Dose	Date: Month/ Year				

In the past 12 months has the camper received treatment for ADD or ADHD? ☐Yes ☐No

In the past 12 months has the camper received treatment for an eating disorder? ☐Yes ☐No

Have a history of violent or destructive behavior? ☐Yes ☐No

Does the camper interact well with other children? ☐Yes ☐No

Does the camper interact well with adults? ☐Yes ☐No

Has the camper experienced a significant life changing event that continues to affect the camper's life? ☐Yes ☐ No
(Death of a family member or pet, history of abuse (physical or mental), adoption, foster care, change in Family (marriage, divorce), new sibling, survived a disaster, etc.)

If "Yes" please explain in the space below.

Any Additional Information – Please provide in the space below any additional information regarding the camper's health that is important.
If necessary, attach additional documentation.

Camper's Last Name _____ First Name _____Middle _____

Date of Birth _____/_____/_____
Month/Day/Year

Enrollment Agreement – Medical Release

Enrollment Agreement (rev 4/12/16)

The above provided information is correct and complete to the best of my knowledge. I/We have read and understand the terms, policies and requirements of attending Camp Frontier and understand that signing this agreement confirms compliance. I/We release and hold blameless the employees, volunteers, and Board of Directors of Camp Frontier, Inc. for any and all claims of liability past, present and/or future. I/We accept the financial responsibility of any and all damage to facilities or personal property for which the child is found to be responsible for. I/We acknowledge that Camp Frontier, Inc. owns and has discretion over the use of all photographs and recordings created while the child is at camp. I/We understand that the total tuition must be paid in full two weeks in advance to the scheduled arrival date unless a payment schedule has been established. I/We authorize the balance due (if any) to be charged to the provided credit card two weeks prior to arrival. Should payment not be made as scheduled, any discounts and/or scholarships may be revoked and the full amount become due including interest. I/We understand that any and all deposits, fees, and/or tuition amount paid is non-refundable even should the camper not attend, go home during camp or be expelled due to dishonest, disrespectful, inappropriate and or violent behavior.

Medical Release *(rev 4/12/16)*

I/We grant permission for my child to participate in all activities offered except as noted by me. I/We give complete authorization from a representative of Camp Frontier to request and receive any medical treatment for the child in the event of need. I/We accept full responsibility for the payment of all medical services provided. I/ We understand that the information on this form will be shared on a "need to know" basis with camp staff.

☐ Agree ☐ Refuse ***(see below)***

If for religious of other reasons, you do not authorize Camp Frontier to provide medical treatment:

I/We release Camp Frontier, Inc. of any liability or medical claims resulting from my decision to refuse medical treatment for the child. I/ We understand that in the event of a medical emergency I/We will be contacted by the Camp Office to establish care for the child. In the event that I/we cannot be reached, the child will be transported to the nearest Hospital/Medical Facility to receive treatment.

Signature: ✘_____Date: ____ /____ /____

Name (Printed) _____Relationship to child: _____

This form **MUST** be notarized

Subscribed and sworn before me this

_____ day of _____, 20_____ (Stamp/Seal)

by _____
who is known to me.

Please mail this form to Camp Frontier, P.O. Box 2555, Riverview, FL 33568, no later than two weeks prior to arrival. If this is not possible, or should you have any concerns or questions, please contact the office by telephone or email.

Minors will not be admitted to Camp Frontier without this completed and notarized form.