

Attendee's Insurance Information

The following information **MUST BE COMPLETED**:

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|-------------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| Insurance Carrier | | | | | | | | | | | | | | | Insurance Co. Phone Number | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy Number | | | | | | | | | | Group Number | | | | | | | | | | | | | | |
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| Subscriber | | | | | | | | | | DOB | | | | | SS# | | | | | | | | | |
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Name of Family Physician: _____

Address: _____ Physician's phone # (____) _____

Father or Guardian name: _____ Phone # (____) _____

Employer Name and Address: _____

Mother or Guardian name: _____ Phone# (____) _____

Employer Name and Address: _____ Phone# (____) _____

Please attach a copy of your insurance card (front and back).

I hereby certify that all the above information is true and complete.

Signature _____ Date _____

Emergency Consent: I, the undersigned, parent or legal guardian of the participant, a minor, hereby authorize the director or other responsible staff acting on behalf of the Arkansas District Council, to act as my Agent, to consent to medical, surgical or dental examination and/or treatment. In case of emergency, I hereby authorize treatment, and/or care at any hospital. If there is an emergency and I cannot be reached, please contact the above emergency contact.

Parent initials _____

Waiver of Liability, Disclaimer, and Permission: I, the parent or guardian of the above-named individual, acknowledge that participation in all camp-related activities involves the risk of physical injury. I further acknowledge that the programs of Arkansas District Camps are primarily administered by adults, who volunteer their time. I attest that my child is physically capable of participating in this event. However, should directors, representatives or volunteers determine in their sole discretion that completion or participation in any games or events would be injurious to my child's health, or should my child become ill or injured, I consent to his or her removal and treatment by any physician or medical care provider at the direction of the event director and/or assistant. I give my permission for free use of any videotape, photographs, audiotapes, or any other visual or audio reproduction in which my student may appear by the Arkansas Assemblies of God. I release the Arkansas Assemblies of God from any liability connected with the use of picture or voice recording as part of any promotion.

Parent initials _____

Discipline/Property Consent: I understand that the Arkansas District Camps and the rented facility make rules and guidelines that my student will abide by while attending camp. I understand that if my student misbehaves and does not respond in a positive manner, I may be called to pick him/her up. Warnings will be given, but if inappropriate behavior continues, I will come and get him/her and no refund will be issued. In addition, **I will pay for any damage that is done to the camp or to personal property belonging to another individual.** I give permission to the camp director and/or assistant camp director to inspect the contents of any or all of my child's personal belongings, and to withhold and/or dispose of any improper or illegal contents.

Parent initials _____

I verify that the information requested is correct and I agree that my camper will conform to all camp regulations and dress code.

Parent /Guardian Signature _____ **Date** _____

(Required if under age 18)

PARENTS: Please complete this MEDICATION FORM. List one (1) camper per form.

Please list all medications, including prescriptions and/or over-the-counter medication, that will be taken at the Teen Girls Retreat in the space provided below.

WILL THIS ATTENDEE BE TAKING MEDS (Prescription or OTC) WHILE AT RETREAT? YES _____ NO _____

ALL PRESCRIPTION, OVER-THE-COUNTER MEDS & INHALERS MUST BE BROUGHT IN THE ORIGINAL BOTTLE TO THE RETREAT NURSE. Please place ALL over the counter meds inside a zip lock bag with student's name & church clearly marked on the outside.

If an attendee must have an inhaler with them at all times, a parent/guardian must complete the Medication Self-Administration consent form enclosed in this packet.

The following information **MUST BE COMPLETED:**

Student's Name: _____

Church Attending: _____

Coordinator's name: _____

Is there any information we should have regarding the welfare of this attendee: handicaps, restrictions, diets, etc.? If this is not enough space, please attach a detailed sheet.

Check if camper has had the following:

Measles ___ Polio ___ Mumps ___ Chicken Pox ___ Whooping Cough ___

Date of the last MMR ___/___/___ Date of last Tetanus shot ___/___/___

Is there any activity you do not wish him/her to participate in? ___ YES ___ NO

If yes, please explain in full. _____

List any medication allergies: _____

List information concerning all medications to be given at camp by the camp nurse.

| Medication (other than Tylenol) | Dosage | Time to be given |
|---------------------------------|--------|------------------|
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Parent/Legal Guardian Signature: _____ **NOTE: Make a copy of this form and send with your attendee/girl's registration form. The original copy or updated copy should accompany your camper's medications on the first day of camp. Please include a copy of your insurance card in case of emergency.**

2024 MEDICATION SELF-ADMINISTRATION CONSENT FORM

(INHALER and/or AUTO-INJECTABLE EPINEPHRINE)

Please complete this form if applies.

Attendee's Name (Please Print) _____

Type of inhaler _____

This form is good for retreat year 2024. This consent form must be updated anytime the attendee's medication order changes and renewed each year and/or anytime a camper changes camp.

The following must be provided for the attendee to be eligible to self-administer rescue inhalers and/or auto-injectable epinephrine. Eligibility is **only** valid for this camp for the current year.

- a written statement from a licensed health-care provider who has prescriptive privileges that he/she has prescribed the rescue inhaler and/or auto-injectable epinephrine for the camper and that the attendee needs to carry the medication on his/her person due to a medical condition.
- the specific medications prescribed for the attendee.
- an individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing asthma and/or anaphylaxis episodes of the attendee and for medication use by the attendee during event hours; and
- a statement from the prescribing health-care provider that the attendee possesses the skill and responsibility necessary to use and administer the asthma inhaler and/or auto-injectable epinephrine.

If the event nurse is available, the attendee shall demonstrate his/her skill level in using the rescue inhalers and/or auto-injectable epinephrine to the nurse.

Rescue inhalers and/or auto-injectable epinephrine for a attendee's self-administration shall be supplied by the attendee's parent or guardian and be in the original container properly labeled with the attendee's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Attendees who self-carry a rescue inhaler or an epinephrine auto-injector shall also provide the event nurse with a rescue inhaler or an epinephrine auto-injector to be used in emergency situations.

My signature below is an acknowledgment that I understand that the Arkansas District Council of the Assemblies of God, the Arkansas District Girls Ministries, and constituents, shall be immune from civil liability for injury resulting from the self-administration of medications by the attendee named above and that the attendee is agreeing to maintain the inhaler and not allow any other person to use it.

Parent or legal guardian signature _____

Date _____