



Shirt Size _____

Participant:

First Name _____ Last Name: _____
Sex ____ Age ____ Date of Birth ____ - ____ - ____ Vision: Sighted Blind Visually Impaired
Mailing Address: _____
City: _____ State: _____ Zip: _____
E-mail: _____
Referred by: _____ School: _____
County: _____

Parent/Guardian:

First Name _____ Last Name: _____
Relationship to Participant: _____ Daytime Phone Number: () _____
Cell Phone Number:() _____

Emergency Contact:

First Name _____ Last Name: _____
Home Phone Number: () _____ Work Phone Number: () _____
Cell Phone Number:() _____
Relationship to Participant: _____

FOR OFFICE USE ONLY

- | | |
|---|--|
| <input type="checkbox"/> HEALTH HISTORY | <input type="checkbox"/> PUBLICITY RELEASE & COVENANT |
| <input type="checkbox"/> MEDICAL INSURANCE INFO | <input type="checkbox"/> TRANSPORTATION |
| <input type="checkbox"/> BEHAVIORAL INFORMATION | <input type="checkbox"/> COPY OF MEDICAL INSURANCE CARD |
| <input type="checkbox"/> PHYSICAL EXAM DATE ____/____/____ | <input type="checkbox"/> CONFIRMATION PACKAGE ____/____/____ |
| <input type="checkbox"/> AUTHORIZATION FOR TREATMENT OF PARTICIPANT CONSENT, RELEASE & COVENANT | <input type="checkbox"/> COUNSELOR ASSIGNED _____ CIT |
| | DATE _____ |



Health History

To be completed yearly by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.
(Front and Back)

Participant:

First Name _____ Last Name: _____

Parent/Guardian:

First Name: _____ Last Name: _____

Health History: (Give approximate dates)

Frequent Ear Infections _____
Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting Disorders _____
Drugs _____
Other _____
Asthma _____

Allergies: (Dates Not Needed)

Hay Fever _____
Ivy Poisoning, etc. _____
Insect stings _____
Penicillin _____
Other _____
Hypertension _____
Mononucleosis _____
Psychiatric Treatment _____

Diseases: (Give approximate dates)

Chicken Pox _____ Measles _____
German Measles _____ Mumps _____

Has the participant ever required hospitalization?
If yes, explain.

Operations or serious injuries:

Disability or chronic illness:

Dietary modifications:

Will camper require a one-on-one aide? If so name of aide-address-phone.
(Please make a copy of insurance card)

For Minor Females: (Not Adults)

Has the person menstruated? _____ if not, does the person have
knowledge of menstruation? _____
If so, is her menstrual history normal? _____
Special consideration? _____

Immunization History:

Required immunizations must be determined locally. Please provide a copy of immunizations the participant has had performed.

Participants with Visual Impairments:

Diagnosis of Visual Impairment: _____
Age Visual Impairment Began: _____
Cause of Visual Impairment: _____ Accident _____ Illness _____ Unknown
Last Eye Examination: _____
Name of Ophthalmologist: _____
List any eye treatments or surgeries:

Does participant wear glasses or use optical aids? _____
Contact Lenses? _____

Other Physical Limitations:

Hearing _____ Speech _____ Smell _____ Orthopedic _____
Developmentally Disabled: _____ Epilepsy (seizures) _____
Explain type: _____
Wheelchair: Yes _____ No _____



Medical Insurance Information

To be completed yearly by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.

Current Medical Insurance is mandatory in order to participate in any recreation activities and events. Any medical costs incurred while participating in any Little Rock Foundation Recreation Program (Camp Little Rock) shall be the responsibility of participant's parents or guardian. Medical costs include physician visit, emergency room visit, prescription medication, and emergency transportation.

I (we) also understand and agree that any and all such medical; dental, hospital or similar expenses incurred in the treatment of my (our) child will be borne by myself (ourselves.)

If a situation requires medical treatment, the parent or guardian will be contacted by a camp staff member and informed of the situation and where the parent or guardian cannot be reached; the child will be taken to the local emergency room facility for treatment.

Please provide us with the following information.

Insurance Company name: _____

Policy number: _____

Participant:

First Name: _____ Last Name: _____

Parent/Guardian: (If under 18 years old)

First Name: _____ Last Name: _____

Signature: _____ Date: _____

Please include a photocopy of medical card being used by participant.



Behavioral Information

The following questions are extremely important! Please be direct and honest, as it will add to the participants well being and enjoyment of the Program.

To be completed by ALL participants attending
the Foundation's Recreation Programs

Does the participant have any unusual or inappropriate habits or behaviors?

What methods are successful in preventing or dealing with said habits and behaviors?

Describe the participant's mobility limitations (Cane, Nighttime Assistance, etc...)?

What are the participant's favorite activities?

What are the participant's least favorite activities?

What will make the participant's trip more enjoyable?

Other comments or concerns?



Physical Examination

Medical examination MUST be filled out and signed by a Licensed Physician (Front and Back)

Name _____ Birth Date _____ Age _____

Home Address _____

Date of Exam _____

City _____ State _____ Zip _____

Date of Last Tetanus _____

Allergies (food, drugs, plants, insect &, etc.)

Height _____ Weight _____ Blood pressure _____

Please indicate any abnormalities and explain, or indicate if WNL

Eyes _____ Heart _____ Rashes (please specify) _____

Glasses _____ Lungs _____

Ears _____ Abdomen _____ Extremities _____

Nose _____ Hernia _____ Posture (spine) _____

Throat _____ Skin _____

General

Appraisal _____

Explanation of any reported loss of consciousness, convulsion or concussion

Does applicant have a history of seizures? Yes _____ No _____

If yes, grand mal _____ petite mal _____

Does applicant have diabetes? _____

Dietary modifications or restrictions

MEDICATIONS BEING TAKEN

Please list ALL medications taken routinely including over-the-counter or non-prescription drugs.

_____ This person takes NO medications on a routine basis.

_____ This person takes medication as follows:

Med. #1 _____ Dosage _____ Times Taken _____

Reason for taking _____

Med. #2 _____ Dosage _____ Times Taken _____

Reason for taking _____

Med. #3 _____ Dosage _____ Times Taken _____

Reason for taking _____

Attach additional pages for more medications.

Camp Little Rock offers a variety of activities. Since the Foundation's Recreation Programs are designed and staffed to allow a maximum of experiences, we offer numerous physical activities. **Explain any restrictions to activity. (E.g. what cannot be done, what adaptations or limitations are necessary)**

_____ NO LIMITATIONS

Physician's Signature _____ Date _____

Initial if completed by Nurse or Physician Assist. _____

Please type or print the following information. (Mandatory)

Physician's Name _____

Address _____

City _____ State _____

Zip _____ Phone () _____



Authorization for Treatment of Participant Consent, Release and Covenant

To be completed by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.
(Front and Back)

The undersigned parent/guardian represents to the Little Rock Foundation that the minor named below is in his and/or her legal custody and control; and that the undersigned desires said minor to participate in the programs of the Little Rock Foundation, and that for purposes of said participation the undersigned agrees, authorizes and states as follows:

In case of medical or dental need or emergency, I (we) undersigned every effort will be made to contact parents/guardians of children. In the event I (we) cannot be reached, I (we) undersigned, parents/guardians of _____, a minor, do hereby authorize the Little Rock Foundation and its officers or staff employees as agent(s) for the undersigned to obtain and consent to any X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered to said minor under the general or special supervision of any and surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital or by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist or the said hospital.

I (we) also understand and agree that any and all such medical; dental, hospital or similar expenses incurred in the treatment of my (our) child will be the responsibility of the parent.

It is understood that this authorization is given in advance of any specific medical or dental diagnosis, treatment or care being required but is given to provide authority and power on the part of the Little Rock Foundation (as aforesaid) as my (our) agent(s), to give specific consent to any and all such diagnosis, treatment or care which a licensed physician or dentist in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective while the child is enrolled in the Foundation's Recreation Programs, unless sooner revoked in writing and delivered.

The undersigned further releases the Little Rock Foundation, its officers, agents and employees from any and all legal responsibility for accidents or sickness occurring during or related to the period of time said person is a participant in programs of the Little Rock Foundation. I (we) further agree and covenant (for valuable consideration, receipt of which is acknowledged) that neither said person or I (we) will institute any suite or action of damage, loss or injury of any kind, whether to person or property, whether to me (us) individually or as parents/guardians relating to the programs or activities of the Little Rock Foundation (including but not limited to Camp Little Rock in which the person participates.)

Participant:

First Name: _____ Last Name: _____

Parent/Guardian: (If under 18 years old)

Relationship to Participant: _____

First Name: _____ Last Name: _____

Signature: _____ Date: _____



Authorization for Publicity Consent and Release

To be completed yearly by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.

Permission is hereby given to the Little Rock Foundation to take pictures, video tape, live television, or otherwise record, preserve, reproduce or depict the activities, voice and likeness of _____ (Participant's Name) and to use any and all of the same for publication, without compensation to said person or to the undersigned on his/her behalf, or individually.

Participant:

First Name: _____ Last Name: _____

Parent/Guardian: (If under 18 years old)

First Name: _____ Last Name: _____

Signature: _____ Date: _____