

**Wilmington Interdenominational Holiness Camp Meeting**  
**Youth Camp**

**Wilmington Youth Camp Covenant**

*Youth and adults have developed this covenant over the years and have found it an effective guideline for discipline. With this signed covenant, there will be no question about our common understanding. Infractions of the covenant will be dealt with by the Youth Camp and Camp Meeting Directors.*

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A Covenant (agreement) between God and yourself:

**I will act as a representative of Christ at all times at Wilmington Youth Camp.**

**I also covenant to:**

**Remember this is a Christian camp where we want to reflect Christian ethics and behavior.**

We will treat one another and our leaders with mutual respect and attitudes of Christian love. We are objects of God's love and need to be treated as such. We also want to encourage one another to grow closer to God, and not act in a way that challenges each other's Christian attitudes.

We will wear proper dress at all times, particularly to dinner and evening service. Shorts can be worn on hikes and athletic activities. If a young man or young woman's attire is too revealing, they will be asked to change.

We will treat God's house with respect.

**Remember this is Camp and we are here to enjoy.**

We will all have an attitude of enthusiasm and participation. The activities and studies are designed for a complete program. Since our time together is only six days, the best way to have fun is to be at all activities and to participate. If you feel ill, inform the camp leaders.

We will complete work assignments (cleaning our dorms rooms, etc.) so we don't lose free/activity time making up for someone else's lack of effort. If someone refuses to do their work, everyone else will complete it and a community discipline will be decided upon.

We will not detract from healthy fun by doing what is unhealthy, i.e. tobacco, drugs, alcohol, improper acts of affection, weapons, or plugging our ears with loud music. These are prohibited on the camp grounds. If anything must be confiscated, it will only be returned by hand to a parent/legal guardian.

Camper's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I agree that the above is reasonable and I support it.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH HISTORY FORM

(To be completed and signed by parent  
or guardian. Please fill in all blanks)

Camper's Name: \_\_\_\_\_

Gender: \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Parent or Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone #: (\_\_\_\_) - \_\_\_\_\_

Parent's Cell #: (\_\_\_\_) - \_\_\_\_\_

If parent /guardian not available, in an emergency call:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: (\_\_\_\_) - \_\_\_\_\_

**Health History:** (please check all that apply and give approximate dates)

Bee sting allergy \_\_\_ (Epipen: yes \_\_\_ No \_\_\_)

High Blood Pressure \_\_\_

Frequent ear infections \_\_\_

Bleeding/clotting disorder \_\_\_

Heart defect/disease \_\_\_

Asthma \_\_\_ (inhaler: yes \_\_\_ no \_\_\_)

Convulsions/seizures \_\_\_

Mononucleosis \_\_\_

Diabetes \_\_\_ Allergies \_\_\_\_\_

Chronic or recurring illness \_\_\_\_\_

Operations or serious injuries with dates: \_\_\_\_\_

\_\_\_\_\_

Dietary Modifications: are there any foods that should be avoided or not allowed?

\_\_\_\_\_

Current medications? Yes \_\_\_ No \_\_\_

(if yes-please complete medication form)

Name of Family Physician: \_\_\_\_\_

Phone #: (\_\_\_\_) - \_\_\_\_\_

Medical/Hospital Insurance information:

Provider/carrier: \_\_\_\_\_

Name of insured: \_\_\_\_\_

ID#: \_\_\_\_\_

Policy or group #: \_\_\_\_\_

IMMUNIZATION HISTORY: (may attach copy of shot records)

OPV/IPV 1.   /  /   2.   /  /   3.   /  /   4.   /  /   5.   /  /    
DPT 1.   /  /   2.   /  /   3.   /  /   4.   /  /   5.   /  /    
dT 1.   /  /   2.   /  /   3.   /  /   4.   /  /    
HIB 1.   /  /   2.   /  /   3.   /  /   4.   /  /    
MMR 1.   /  /   2.   /  /    
HBV 1.   /  /   2.   /  /   3.   /  /    
Varicella 1.   /  /    
Other 1.   /  /   2.   /  /   3.   /  /    
Other: \_\_\_\_\_

The camper is under the care of a physician for the following condition(s):  
\_\_\_\_\_

Any treatment/restrictions to be continued at camp?  
\_\_\_\_\_

This health history is correct as far as I know and the applicant has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp

1. to provide ongoing health care
2. to select medical personnel and provide for treatment of this camper

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper. This form may be photocopied for use out of camp.

Signature of parent/guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date:   /  /  

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NYS Public health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven or more nights. Check one box and sign below:

       My child has had the meningococcal meningitis immunization

(Menomune) within the past ten years. Date received:   /  /  

Note: The vaccine's protection lasts for approximately 3-5 yrs. Revaccination may be considered within 3-5 yrs.

       I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed \_\_\_\_\_ Date   /  /    
Parent or Guardian

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I (CIRCLE ONE) **grant/ do not grant** permission for my child to attend any out of camp trips chaperoned and sponsored by the Camp

Signed \_\_\_\_\_ Date   /  /

## Approval For Medication Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Camp personnel are often asked to give medicine to campers. These medicines may be in the form of eye drops, pills, tablets, capsules, ointments or liquids; they may be prescribed or over-the-counter medications. The camper's physician must approve both prescription and over-the-counter medication. Over-the-counter medication noted below will be available at the nurse's station and administered (as the label directs according to age and weight) at the discretion of camp medical personnel **if approval is indicated by the camper's physician.**

No campers or counselors may keep any medication in their lodging. All medicines must be locked in the camp dispensary. Any loose medications (including vitamins) will not be accepted unless they are in the original container and clearly specified **on this form by the camper's physician.**

### Medications Schedule

Drug Name	Dosage	Schedule and Indications	Physician's Order	Comments
Tylenol	per label	Q 4 hr prn for pain or fever	Yes / No	
Ibuprofen	per label	Q 6 hr prn for pain or fever	Yes / No	
Robitussin	per label	Q 4 hr prn for cough	Yes / No	
Pepto-Bismol	Per label	Q ½ - 1 hr prn for intestinal disturbance	Yes / No	
Dimetapp	Per label	Q 6 hr prn for allergic reaction	Yes / No	
Benadryl	Per label	Q 6 hr prn for allergic reaction	Yes / No	

*(Generic Brands may be substituted)*

The above named individual is under my care for \_\_\_\_\_  
*Condition or Diagnosis (if any)*

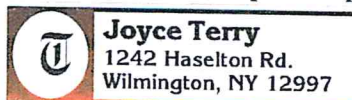
The above listed over-the-counter or prescription medication(s) are approved for the named camper and may be administered by camp medical personnel as required.

Special instructions: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician's Signature: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**This form must be returned as soon as possible prior to camp to:**



*copy form as needed*