

Matthew Salem Camp 2024 Camper Application

Camper's Name _____ Female _____ Male

Nickname (if any) _____

Parent/Guardian Name(s) _____

Street Address _____ City _____

State _____ Zip Code _____ Home Phone _____

Email Address _____ Cell Phone _____

Camper's Birthday _____

Physician's Name _____ Phone Number _____

T-Shirt Size _____ AL _____ AM _____ AS _____ YXL _____ YL _____ YM

Payment Schedule

A \$100 **non-refundable** deposit is required at registration. All campers who register after May 31, 2024 must pay the entire camp fee at the time of registration. All camp fees are non-refundable. **Campships are available for those who qualify

Camp Tuition (\$300 Total) \$ _____

Less Deposit (due with application) \$ _____

Balance Due by May 31, 2024 \$ _____

I agree that Matthew Salem Camping Foundation, Inc., its agents, employees, and volunteers shall not be liable to me or my child for any injury or damage, howsoever caused, resulting directly or indirectly from my child/guardian's participation in Matthew Salem Camp at any time preceding, during or after camp is in session. I hereby discharge Matthew Salem Camping Foundation, Inc., its agents, employees, and volunteers from all actions, claims or demands I or my child may have for such injury or damage. I authorize that Matthew Salem Camping Foundation, Inc. has the right to use all photographs or videos taken of my child during camp for advertising or promotional purposes.

A Health Record/Medical Release form must be completed and returned before camp enrollment dates in order for the camper to participate in any camp activities.

Parent or Guardian Signature _____ Date _____

Send application with payment to: Matthew Salem Camp *PO Box 670178*Northfield, OH 44067

COVID-19 Liability Waiver and Assumption of Risk

In consideration of being allowed to participate in Matthew Salem Camp, the below signed camper's parent(s) or legal guardian(s), agrees as follows:

1. I am aware that the novel coronavirus ("COVID-19") is an extremely contagious virus and that it is currently believed that COVID-19 spreads through person-to-person contact.
2. I am familiar with the Center for Disease Control and Prevention ("CDC") guidelines regarding COVID-19, which are located at <https://www.coronavirus.gov> and <https://cdc.gov/coronavirus/2019-ncov/index.html> I acknowledge and understand that the circumstances regarding COVID-19 are changing from day-to-day and that the CDC guidelines are regularly modified and updated. I accept full responsibility for familiarizing myself with the most recent updates and making informed choices to take precautionary measures to protect myself and others.
3. In addition to the CDC guidelines, I agree to abide by any and all policies or postings published to the general public at Matthew Salem Camp.
4. By signing this agreement, I acknowledge that I am aware of the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 at Matthew Salem Camp and that such exposures or infection may result in personal injury, illness, permanent disability and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Matthew Salem Camp may result from the actions, omissions, or negligence of myself and others.
5. I agree that, in the event that I suspect that my child(ren) became exposed to or infected by COVID-19 at Matthew Salem Camp and I elect to seek testing and/or treatment therefrom, I will be responsible for the payment of any and all medical services and testing services.
6. I voluntarily choose to assume all of the foregoing risks and accept sole responsibility for any injury, illness, permanent disability, or death related to COVID-19 arising from or in connection with my child(ren)'s presence at Matthew Salem Camp. I hereby release and hold harmless Matthew Salem Camping Foundation, Inc., its employees, agents, directors, officers, representatives, volunteers and other participants from and against all liabilities (statutory or otherwise) for claims, suits, demands, judgment costs, interest and expense (including but not limited to attorney's fees and disbursements) for injury, illness, permanent disability or death related to COVID-19 arising from or in connection with my child(ren)'s presence at Matthew Salem Camp. EVEN IF ARISING FROM THE NEGLIGENCE, ACTS OR OMISSIONS OF THE RELEASED PARTIES.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I AM AWARE THAT BY SIGNING BELOW I MAY BE WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE.

Camper Name(s) _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Matthew Salem Camp Health History and Care Services

This information is needed to ensure that your son or daughter will receive the best possible care in the event of an accident, illness or emergency. **This form MUST be completed and signed by a parent or guardian and is valid for only one calendar year.** This information will be kept confidential and used only for the participant's welfare. PLEASE PRINT OR TYPE

Name: _____

Street Address: _____ City/State/Zip _____

Date of Birth: ____/____/____ Male _____ Female _____

Email Address: _____

Home Phone Number (_____) _____

In case of emergency, contact us in this order:

Please list ALL medical diagnoses as they pertain to your camper:

INSTRUCTIONS FOR MEDICATIONS: Prescription Drugs/Over-the-Counter Medications. Please complete the following information on all medications required by your child. All prescription drugs needed must be given to the nurse/health care provider for storage and dispensing.

Please put all medications in a zip lock bag with your child's name on it.

CHECK IF CAMPER IS SUBJECT TO:

	Athlete's Foot		Ear Infections		Home Sickness
	Bed Wetting		Epileptic Seizures		Kidney Trouble
	Bronchitis		Fainting		Sinusitis
	Constipation		Frequent Colds		Sleep Walking
	Convulsions		Frequent Sore Throat		Other
	Cramps		Headaches		Other
	Diarrhea		Heart Trouble		Other

The following is a list of items which the camp will have on hand during your child's stay at camp:

PLEASE CHECK EACH ITEM YOU GIVE PERMISSION FOR YOUR CHILD TO HAVE DURING CAMP IF NEEDED:

	Advil: 100 mg tablets		Cortisone Cream 1%		Tylenol: 80 mg per tablet
	Benadryl: 12.5 mg tablets		Triple Antibiotic Cream		Tums Regular Strength

A listing of each medication brought to camp (prescription or non-prescription-over-the-counter medication) must be provided. Please copy form if necessary

Medication Section

Name of Medication	Mg provided In	Dosage Administered	Time(s) Administered	Precautions/Possible Reactions

CAMPER ALLERGIES (please be specific):

Foods _____

Serious Ivy, Oak or Sumac Poisoning _____ Bee or Insect Stings _____

Allergy Medication: Prescription or Non-Prescription Drugs:

Special Dietary Needs:

**PLEASE SPECIFY DETAILS OF ANY OTHER PREVIOUS MEDICAL CONDITIONS, ACCIDENTS OR INJURIES
WITHIN THE LAST 5 YEARS (INCLUDING BREAKS, SPRAINS OR STRAINS)**

SPECIFY ANY RESTRICTIONS IN ACTIVITIES: _____

PARENT/GUARDIAN MEDICAL RELEASE

_____ (Child's name) has my permission to participate in Matthew Salem Camping Foundation, Inc.'s program (with the exception of those listed above). I understand the participants will be supervised. I understand that the volunteers of the Matthew Salem Camping Foundation are not responsible in the event of accidental injury or illness, nor for the compounded injury or illness to the participant's present medical conditions listed above. I the undersigned, who is the parent/guardian of the above mentioned child, request that the health care service outlined above and prescribed by the above physician be provided to my child. I authorize the camp to appoint a qualified designated person(s) to perform the above prescribed treatment as directed by the physician. I agree to notify camp personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.

I further understand that in case of serious injury or illness I will be notified. If I cannot be contacted, I give my permission to transport or arrange the transportation to an appropriate medical facility and for the attending physician to hospitalize, secure proper treatment and to order injections, anesthesia or surgery for the participant named above.

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____ Date _____