



CAMP BENNETT 2020

CAMPER APPLICATION

To Reach, Teach, and Keep Children for Christ
Christian Summer Residential Camp for Children Age 8-12

A MINISTRY OF CENTRAL UNION MISSION

PO Box 96763, Washington, DC 20090-6763

Phone: 202-745-7118 www.missiondc.org www.campbennett.org

Joe Mettimano, President

Michael Tate, Camp Director

Office Use Only

Date: _____

Birth Cert. _____

Medical Forms _____

Heart: _____ Paid: _____

Cabin: _____

Camp Week: _____

Please Note... All applications must include:

- **EVERYONE IS REQUIRED** to provide a copy of your **child's birth certificate**. Maryland state law requires that you must submit your **child's immunization record** even if your child has attended camp previously.
- **Doctor's signature** is **REQUIRED** for the forms of children with asthma bringing an inhaler or prescription medications to camp.
- **\$30 per child**, per child registration – CASH and MONEY ORDER, payable to *Central Union Mission*. **NON-REFUNDABLE**
- Applications without this paperwork will not be processed. Admission is as space permits on a first come, first served basis. A confirmation letter will be sent to the address provided below.

Personal Contact Information (Please Print Legibly)

Child's Name (First, Last) _____

Male ___ Female _____ Birth date ___/___/___ **Age AT CAMP** this summer. _____

(Ages 8-12yrs. accepted)

Child's first time attending Camp Bennett? YES or NO (Circle One)

Street Mailing Address: _____

***Confirmation letter & packing list will be mailed to this address.**

City _____ State _____ Zip Code _____

Email: _____

May we **E-MAIL** the confirmation packet? YES or NO

Custodial Parent/Guardian Name: _____

Relationship to Child: _____

Best phone number to reach you: _____

If not available in an emergency notify: _____ Phone Number: _____

Roommate Preference: _____

*Roommates assigned based on cabin availability. Recommend applications turned in together for best results.

Is your child coming with a Group/School/Organization? Name: _____

Camp Sessions 2020: Please indicate your TOP (2) choices:

Write (1) and (2) for your top two preferences.

Week 1: June 29-July 3 _____

Week 2: July 6-10 _____

Week 3: July 13-17 _____

Week 4: July 20-24 _____

Week 5: July 27-30 _____

For Camp Bennett 2020 we will ONLY have ONE drop-off location

Family Ministry Center, 3194B- Bladensburg Rd. NE, WDC 20018
Drop-Off Monday, 2:00-3:00PM Pick-Up Friday, by 2:30PM

Required Signatures

Permission to Photograph or Video

I grant permission for my child to be photographed and/or videoed while [s]he is participating in Camp Bennett or Central Union Mission activities. I understand that any photographs and video may be published or used by Central Union Mission for promotional publicity, historical purposes, and the like. I further understand that I am relinquishing all legal rights for payment or redress with respect to the publication of any photographs and video.

**PLEASE
SIGN!**

Signature _____ **Date** _____
Custodial Parent/guardian

Signature _____ **Date** _____
Custodial Parent/guardian

Please Note: In cases of joint custody, signatures of BOTH parents/guardians is required

By signing below I grant permission for my child to participate in Central Union Mission's summer camp at Camp Bennett without restriction, to include off-site field trips if such should be planned. I grant Central Union Mission permission to transport my child to and from the Mission and on (yet unscheduled) field trips. I acknowledge that I am required to supervise my child until they depart and arrive from camp. I also acknowledge that Camp Bennett utilizes a high ropes course, an outdoor swimming pool as part of its activities and have had opportunity to inquire regarding the nature of these activities and give full permission for my child to participate in these activities.

PLEASE SIGN!

Signature _____ **Date** _____
Parent/guardian

Signature _____ **Date** _____

Note: In cases of joint custody, signatures of BOTH parents/guardians are required.

Camp Bennett Health Information

Primary Care Provider/Physician Information

(Please Check ONE)

- Office Use Only
Checklist for Health Information
- PCP Information
 - Immunization Record
 - Signature line

_____ Participant **DOES NOT** have a Primary Care Provider/ Physician at this time.

_____ Participant **DOES** have a Primary Care Provider/Physician.

PCP/Physician_Phone No. _____ PHONE: _____

INSURANCE INFORMATION

(Please Check ONE)

_____ Participant **DOES NOT** have health care coverage at this time.

_____ Participant has health coverage (fill in below):

Insurance Provider _____ Phone # _____

Policy Holder _____ Policy # _____

Group # _____ Effective Date _____

***All staff/campers under the age of 18 are required to provide Camp Bennett with a copy of immunization records including those who attend Maryland private or public school.**

Is the participant exempt from immunization for medical or religious grounds? __Yes__ No
(See below)

For participants who reside outside the United States, a United States territory, or the District of Columbia: Country in which child resides _____

Please attach Department form DHMH-896.

(Record of vaccination or immunity)

All staff/campers must be current on all immunizations, unless they provide a written statement from either their physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons. *If either of these situations applies to you, you must provide a copy of the Maryland Department of Health and Mental Hygiene Immunization Certificate for your child. (Included in your health packet)*

Date of most recent Tetanus Immunization Booster: _____

(Must list month and year)

Will your child bring an inhaler to camp? Yes or NO

(If YES - REQUIRED: Please fill out the Asthma Action Plan form)

Will your child bring an epi-pen to camp? _____ Is your child ADD or ADHD? _____

Will your child bring any medications to camp? ***If yes, I would like to inform the camp that at least one dose of the medicine was given to my child at home. (REQUIRED: Please fill out Medication Authorization Administration)***

Signature _____

Date _____

General Questions (Check only those that apply. Explain "Yes" answers below)

Has/does the participant:	YES	YES
1. Had any recent injury, illness or infectious disease? (within the last 6 months).....		12. Ever had problems with joints (e.g. knees, ankles, etc.)?.....
3. Have a chronic or recurring illness/condition? Ever been hospitalized?.....		13. Have any skin problems (e.g. rash, itching)?
4. Ever had surgery?.....		14. Have diabetes?
5. Ever had a head injury?.....		15. Have asthma? (See Asthma form).....
6. Wear glasses, contacts or other eyewear?....		16. Have mononucleosis in the past 12 months?
7. Ever had frequent ear infections?.....		17. Had problems with diarrhea/constipation.....
8. Ever had seizures?.....		18. Have problems with sleepwalking.....
9. Ever had high blood pressure?.....		19. Have a history of bed-wetting.....
10. Ever been diagnosed with a heart murmur?		20. Ever had emotional difficulties for which professional help was sought?.....
11. Ever had back problems?.....		21. Please list allergies below (food, drug, Environmental).....

Please explain any "yes" answers

_____ This participant takes **NO medications** on a routine basis. Some over-the-counter medications may be supplied by the health center as needed. (See list below) Be certain you have listed allergy information.

Please circle medications in the box below you **DO NOT** want the participant to receive

I approve my camper to take all of the flowing medications as needed **EXCEPT** (please circle):
Any meds NOT listed require a doctor's order (Complete Medication

- | | | |
|------------------------|----------------------------------|-----------------------------|
| - Hydrogen Peroxide | - Tylenol | - Chloraseptic throat spray |
| - Antiseptic spray | - Benadr yl | - Throat lozenge |
| - Antibiotic ointment | - Ibuprof | |
| - Hydrocortisone cream | - Cough suppressant/expectorant | |
| - Calamine lotion | - Antacid (Tums or Pepto-Bismal) | |

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health of which the camp should be aware (including learning disabilities).

Health Services Authorizations

This health history is correct and complete as far as I know. The completed form may be photocopied for trips out of camp.

I agree that Camp Bennett, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to myself or my child, and/or anyone claiming on my or my child's behalf, and I further agree to hold harmless, indemnify and defend Camp Bennett, its officers, staff, agents, employees, trustees and volunteers for and from any and all liability, claims, losses, injuries, expenses, fees and/or damages arising out of any injury, illness or death to myself or my child or property damage during my or my child's attendance at Camp Bennett. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including order x-rays or routine tests, and ordering injections and/or anesthesia or dental work. I agree to the release of any records necessary for insurance purposes.

In accordance with government HIPAA Regulations, I hereby authorize Camp Bennett's health officials to share health information and health history with the other staff members on a need to know basis. This includes the camp director, head counselor, and counselors that have the participant in their care. The purpose of this disclosure is for the necessary staff to be prepared in advance for any medical emergencies. The health information that may be disclosed will be from the Health Information Form, Medication Form and Immunization Records. I authorize release of medical information to Dr. David Harding and associates, Camp Bennett's physician, for necessary treatment while attending camp. I also authorize the release of medical information from my child's doctor's office to Camp Bennett. This authorization is valid from June 26 through July 31. I understand that this information is released to help with treatment.

Additional Parent/Guardian Authorizations for participants under 18: The minor child herein described has permission to engage in all camp activities except as noted. I give permission to the camp for the use of camp stocked over-the-counter medications to be administered as ordered by the camp physician. In the event of an emergency, I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for my child.

**PLEASE
SIGN!**

Signature of parent/legal guardian: _____ Date: _____

_____ I have submitted with this application **cash or money order** for \$30 (*payable to Central Union Mission*) to cover my child's registration fee, and I understand this payment is **NON-REFUNDABLE**.

_____ I have submitted with this application copy of my **child's Birth Certificate**
(Requirement for everyone)

_____ I have submitted with this application a copy of my **child's immunization records**
(Requirement for everyone)

_____ I have submitted with this application the **Health Information** forms required.

Mail Completed Applications to:
Central Union Mission, Attn: CAMP BENNETT, PO BOX 96763,
WASHINGTON DC 20090-6763

Any questions regarding camp activities or curriculum please contact:
Michael Tate of Camp Bennett: (301) 327-3313 mtate@missiondc.org or
Visit WWW.CampBennett.org