

MATTHEW SALEM CAMPING FOUNDATION

5960 Highland, Highland Heights OH 44143

acwmlroy@gmail.com

2026 CAMPER APPLICATION (Sunday, July 26 - Saturday, August 1)

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 YM _____ YL _____ YXL _____ AS _____ AM _____ AL _____ AXL _____ A2XL _____

Payment Schedule

A \$100 non-refundable deposit is required at registration. All campers who register after May 31, 2026 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 (\$350 Total) \$ _____

Less Deposit (due with application) \$ _____

Balance Due by May 31, 2026 \$ _____

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 5960 Highland Road, Highland Heights, OH 44143**

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:

<input type="checkbox"/>	Athlete's Foot	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Home Sickness
<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	Epileptic Seizures	<input type="checkbox"/>	Kidney Trouble
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Sleep Walking
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Frequent Sore Throat	<input type="checkbox"/>	Other
<input type="checkbox"/>	Cramps	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Other
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	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:

<input type="checkbox"/>	Advil: 100 mg tablets	<input type="checkbox"/>	Cortisone Cream 1%	<input type="checkbox"/>	Tylenol: 80 mg per tablet
<input type="checkbox"/>	Benadryl: 12.5 mg tablets	<input type="checkbox"/>	Triple Antibiotic Cream	<input type="checkbox"/>	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 _____