Matthew Salem Camp
2025 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, 2025 must pay the entire camp fee at the time of registration. All camp fees are non-refundable. **Camperships are available for those who qualify

Camp Tuition ($300 Total) $_____

Less Deposit (due with application) $_____

Balance Due by May 31, 2025 $_____

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:

	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 CHIILD 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)

_____

_____

_____

SPECIFIY 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 _____