For camp office use only: Counselor _____ Cabin _____

REGISTRATION for CAMP METIGOSHE
OJIBWA WEEK – 2020

Parental guardian complete and sign. Please use pen.

CHECK ONE: ☐ We can pay the full $200.00 camp fee. ☐ We can pay only $10 and request a $190.00 campership.

☐ We can pay $_____ and request a campership in the amount of $_____.

GENERAL INFORMATION

Camper's first & last names_____Gender_____Birthdate_____Age_____

Parent(s)/guardian(s)_____Home phone_____Other phone_____

Mailing address_____City_____State_____Zip code+4_____

Work telephone numbers (if applicable) of Mother_____Father_____

Cabinmate request (optional), please list first and last names_____

Family physician's name_____Telephone_____

If applicable: Affiliated clinic/town of family physician_____Telephone_____

If a parental guardian is not available in case of emergency, notify:

Name(s)_____Telephone(s)_____

The camp bus should drop camper off at: ☐ North Dunseith Housing ☐ East Dunseith Housing ☐ Shell Valley ☐ Center Site

HEALTH HISTORY and MEDICAL INFORMATION (CHECK ✓ ALL THAT ARE PERSISTENT HEALTH PROBLEMS.)

ADD/ADHD ☐ Anorexia/Bulimia ☐ Appendicitis ☐ Arthritis ☐ Asthma ☐ Bedwetting ☐ Behavior challenges ☐

Bladder/Kidney problems ☐ Constipation ☐ Convulsions/seizures ☐ (*If applicable,* type) _____ Depression ☐

Diabetes ☐ Diarrhea ☐ Ear infections ☐ Eczema ☐ Epilepsy ☐ Fainting spells ☐ Hay fever ☐ Headaches ☐

Heart trouble ☐ Hepatitis and/or known carrier ☐ Homesickness ☐ Hypertension ☐ Measles ☐ Menstrual cramps ☐

Mumps ☐ Nervousness ☐ Nosebleeds ☐ Rheumatic Fever ☐ Sinus trouble ☐ Sleep Walking ☐ Ulcers ☐

Other chronic or recurring illnesses_____

(Please include any necessary information regarding treatment or management.)

Surgeries or serious injuries and dates_____

ALLERGIES: foods/medications/insects, etc._____

Dietary concerns/restrictions_____

Physical activities to be encouraged or restricted_____

MEDICATIONS - All medications will be administered by camp staff except inhalers which will be self-administered by camper. All prescription medication must be appropriately labeled. Please list any routine daily medications including dosage and directions.

_____

The camp has a supply of non-asprin pain relievers, cough medicine, decongestants, antacids, and first-aid ointments which will be used as indicated following label instructions, so campers do not need to bring their own. Please state any concerns or give instructions regarding use of over-the-counter medications.

_____

IMMUNIZATIONS Completion of the chart below is mandatory **OR** please attach a copy of the immunization record. Please list month and year of vaccination; do not use "current" or "up-to-date."

Date of last Tetanus Shot _____
Month/Year

Pertussis (Whooping Cough) _____ **OR** ☐ Not Vaccinated
Month/Year

*Please note, the pertussis vaccine may have been given in combination with the tetanus vaccine and would have been called DTaP or Tdap.

MMR _____ _____ **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2

Meningitis (MCV_4) _____ **OR** ☐ Not Vaccinated
Month/Year

Chicken Pox _____ _____ **OR** ☐ Has had Chicken Pox **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2

Hepatitis B (HBV) _____ _____ _____ **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2 Month/Year shot #3

FAMILY MEDICAL/HOSPITAL INSURANCE INFORMATION

Insurance Carrier_____ Name of Insured_____

Group Policy Number_____ Insured's Policy Number_____

PARENTAL GUARDIAN'S SIGNATURE TO THE FOLLOWING IS REQUIRED.

My child has my permission to ride the bus to Camp Metigoshe and return home on the bus. My child has permission to participate in normal camp programs at Camp Metigoshe on- or off-site. Metigoshe Ministries has my permission to use photos and/or slides that may be used for promotional purposes.

I attest that the health history and medical information are correct to the best of my knowledge. The person herein described has permission to engage in all prescribed camp activities, except as noted by me. I agree that Metigoshe Ministries and/or its personnel will not be held responsible for accidents or personal injury arising there from.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the camp director to order X-rays, perform routine tests, and treat my child; and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and order injection and/or anesthesia and/or surgery for my child named herein. I give my approval to photocopy this form for use out of camp.

SIGNATURE OF LEGAL GUARDIAN_____DATE_____

Metigoshe Ministries
165 Lake Loop Road
Bottineau ND 58318