St. John Lutheran Church
1600 S. Orlando Ave.
Winter Park, FL 32789
Phone: 407-644-1783/FAX 407-644-8913
www.mysj.org

Vacation Bible School, June 15-19, 2009
Held from 9:00 a.m.-12:30 p.m.
Please return forms to Church Office or
by email to TinaRegan@cfl.rr.com ASAP

SPLASH IN HIS PROMISE

VACATION BIBLE SCHOOL
DAY CAMP CAMPER REGISTRATION FORM

Camper's Full Name:			Gender:	Date of Birth:	Age:
Parent/Guardian Name:					
Address:	City:		State/Zip:		
Home Phone: Cell Phone:	Work Phone: Beeper:		Elementary Grade **just completed** (circle one) K 1 2 3 4 5 6		
If not Available, in Emergency Call or Notify: (name)		Address:		Phone: Phone:	

I give my permission for my child to attend St. John Lutheran's Vacation Bible School Program. I also consent to the use of any photography and/or video of my child in future St. John's Publications.

Parent/Guardian Signature ____ Date __________________________

PARENT DROP-OFF & PICK-UP INFORMATION/AUTHORIZATION

Child's Name_________________________________ Parent's Name ____

Persons authorized to pick-up my child - **INCLUDE PARENTS/GUARDIANS.**

Name:____ Driver's License # ________________________________

Name:____ Driver's License # ________________________________

Name:____ Driver's License # ________________________________

Name:____ Driver's License # ________________________________

Safety and Security are of primary importance to us. For this reason, you will receive 5 pick-up tickets for each of these individuals. When you/they come to pick-up your child, you/they MUST present the appropriate ticket and be prepared to show their license for identification.   It is your responsibility to see that these individuals receive their tickets.

HEALTH FORM

NOTE: **A physical is required only if there are any health problems or activity limitations noted in the health history on the health form.** If there are no health problems or activity limitations listed, a physical is not needed. Please complete the following form and return to the Day Camp Coordinator prior to your week of camp. For campers under 18 years of age, this health form must be completed. Parents must complete the following form:

In the event of an accident or injury requiring medical attention, your personal insurance will be considered the primary carrier.

Company Name: ______________________________ Policy #: _____________________________

Company Address: ____ Zip: _________________

HEALTH HISTORY: (Check - give approximate dates)

- ❑ Diabetes_____________________
- ❑ Allergies: ____________________
- ❑ Convulsions___________________
- ❑ Hay Fever____________________
- ❑ Rheumatic Fever______________
- ❑ Penicillin______________________
- ❑ Ear Infections________________
- ❑ Poison Ivy____________________
- ❑ Chicken Pox___________________
- ❑ Insect Stings_________________
- ❑ Measles______________________
- ❑ Other Drugs___________________
- ❑ Asthma_____________________

Operations or Serious Injuries (dates): ____

Chronic or Recurring Illness: ____

IMMUNIZATION HISTORY: Please note date of shots or most recent booster doses. **If dates are unknown, please indicate if the camper has received the immunization.**

DtaP/DTP Series: ______________ ___________ ___________ ___________ ___________

DT: ________________________ ___________ ___________ ___________ ___________

Td: ________________________ ___________ ___________ ___________

Polio: ______________________ ___________ ___________ ___________

Hib:________________________ ___________ ___________ ___________

MMR combined:_______________ ___________

MMR separate: _______________ ___________ ___________ ___________

Hepatitis B: _________________ ___________ ___________

Varicella: ___________________ ___________ Varicella Disease: ______________________

Tetanus: ____________________ Tetanus Booster: _______________________

DOCTOR'S REPORT: (REQUIRED **ONLY** IF CAMPER IS UNDER A DOCTOR'S CARE)

KNOWN ALLERGY: PLEASE SPECIFY____

KNOWN FOOD ALLERGY: PLEASE SPECIFY____

MEDICATIONS TO BE BROUGHT TO CAMP ____

RECOMMENDATIONS OR RESTRICTIONS WHILE AT CAMP _____________________________

I have examined the person herein described within the past 24 months and have reviewed his/her history. It is my opinion that he/she is physically able to engage in camp activities except as noted above.

Signature of Physician_______________________________________ Date__________________________________

Business Phone (_____)____________________________ Emergency Phone (_____)___________________

Business Address ___________________________________ City, State, Zip_____________________________

PARENTS' AUTHORIZATIONS:

I give my permission for my child to attend St. John Lutheran Church's Vacation Bible School. I also consent to the use of any photography and/or video of my child in current or future St. John Lutheran Church's publications.

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and/or the examining physician.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

I also give permission for the camp to administer the following over-the-counter medications if the staff or nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Headache	Acetaminophen (Tylenol®)
Menstrual Cramps	Ibuprophen
Poison Ivy	Calamine Lotion or CortAid®

____ _________________________

Signature of Parent or Guardian Date