2024 Camper Application

Camp Cherokee rules for acceptance and participation are the same for everyone, without regard to race, color, creed or national origin.

Please type or print neatly. Must be signed by parent or guardian:

Camper's Name (Last, First, Middle) | Home/Cell Phone | Parent/Guardian Work Phone

Street/City/State/Zip

Date of Birth | Grade | Gender: ____ Male ___ Female

Home Church | Desires Baptism at Camp: ___ Yes ___ No

Email Address

Parents, Please Initial Applicable Statements (1&2 required)

____ I give my permission for a doctor or nurse to treat my child in the event of an emergency. My child suffers from no chronic illnesses. I understand that my own medical insurance policy will be applied to any medical/hospital costs incurred.

____ I have read the camp brochure and will comply with all regulations, policies and procedures stated therein.

____ I permit Camp Cherokee to use photographs of my child for promotional purposes.

____ I give permission to my child to participate in the following camp activities: horseback riding, tubing, swimming, archery, Rockwall climbing, crafts, and their described difficulty and risk level as outlined on www.campcherokeeadk.com.

____ I give permission for sunscreen and/or bug spray to be applied to my child.

____ I understand that registration begins at 2:00 pm in the cafeteria

____ I agree to the policies regarding electronic devices. I understand that this policy requires NO ELECTRONIC DEVICES in possession of the camper at camp throughout the duration of the week. I agree to not have any electronic devise (cell phones, iPhones, iPods, MP3 players, hand-help gaming devices, etc.) while I am at camp. I understand that any electronic device that is found in my possession will be confiscated. I understand that Camp Cherokee is not responsible for any device that is brought to camp. I agree that any confiscated device will be returned to me only at my payment of the required $25 fee at the end of the week.

Signature of Camper | Date

Signature of Parent/Guardian | Date

Fees: $474.00 ___ Picture - $5.00 ___ CD - $10.00 (***check box & include with total below.)***

Camp #	Camp Date	Camp Selection(s)	Camp Cost
1	June 30-July 7	Teen Camp	
2	July 7-14	Junior/Tween Camp	
3	July 14-21	Adventure Camp	

* $100 deposit is part of the total camper fee.
** If paid in full and postmarked by June 1st. *(No discount after June 1)*
*** If paying by credit card, a 3% surcharge will be added to the total.

Send completed application, Health History/Physical Exam, Release, and non-refundable deposit to:

Camp Cherokee/New York Conference
P O Box 15502, Syracuse, NY 13215

NY Conf. Member Discount ($25)		
Early Bird Discount ($25)**		
Store/Offering		
Picture/CD		
TOTAL* **		

$100 DEPOSIT REQUIRED WITH APPLICATION

This deposit is **non-refundable** unless cancellation is two weeks prior to Camp.

For Office Use Only								
Date	Rec#/Ck#	Total Ck	Fee	Store	Offering	Picture	DVD	Balance

Camper Health History/Physical Exam Form

(NOT NEEDED FOR FAMILY CAMPS)

Fill in all requested information. Incomplete forms cannot be processed and will be returned. Forms are due two (2) weeks before your Child's session begins

Camper Name_____

Physical Examination - To be filled out by a licensed healthcare provider *New York State law requires a signed/dated physical exam, within the last 12 months and dates of most current boosters*

Immunization History - Must be completed with dates or enclose a copy. Please record the date (month and year) of basic immunizations and most recent booster doses:

___ DPT or DT ___Tuberculosis ___ Other tetanus ___ Hepatitis vaccination ___ Chicken Pox Vaccine
___ MMR ___ Polio vaccine (most recent) ___ Pneumonia vaccination ___ Recent exposure to contagious disease ___ Flu vaccine

General Condition or Appraisal

Birthdate _____ Nutrition_____ Allergy Athlete's foot_____
Height _____ Nose _____ Foods_____ Impetigo _____
Weight_____ Throat-tonsils_____ Drugs_____ Infection _____
Posture & Spine_____ Lungs _____ Other_____ Pediculosis _____
Feet_____ Eyes Abdomen_____ Current conditions (diabetic, seizures, etc.)_____
Teeth _____ Discharge _____ Genitals_____ _____
Blood pressure_____ Glasses_____ Hernia _____ _____
Heart murmur _____ Menstruation_____ Skin _____
Ears_____ Urine _____ Scabies_____ _____

Standard Over the counter/PRN medications: (The following medications are available in the infirmary and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider)

Drug Name	Route (indicate formulation[s])	Dosage	Schedule & Indications	Healthcare Provider Initials	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (prn)		
Acetaminophen (Tylenol)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 4 hr prn for pain or fever >_____^{0}F		
Ibuprofen (Motrin)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever >_____^{0}F		
Diphenhydramine Hydrocholoride (Benedryl)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream or Benadryl Cream	Topical	Per label instr. by age/weight	prn - itching		
Bismuth Subsalicylate (Pepto-Bismol)	PO (Liquid or chewable tabs)	Per label instr. by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)		
Loperamide HCl (Immodium)	Tab or liquid	Per label instr. by age/weight (max of 8 mg/24 hr)	Per episode/ max 8 mg/24 hr		
Tums	Chewable tab	Per label instr. by age/weight	No>10 tabs/24 hrs		
Throat Lozenges/Cough Drops	Tab	1 Lozenge	No>6/24 hr		

Prescription Medications (please complete with patient's current regimen for both scheduled and prn medications)

Drug	Route	Dosage	Schedule & Information	Comments

Additional Orders (as deemed necessary by healthcare provider to be implemented by an RN (i.e. peak flows, dressing changes, cast care, etc.)

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations (attach specific instructions or medications, treatments and diet):

Provider's Name (print) _____ License #:_____
Providers Signature _____ Date:_____
Address:_____ Phone:_____

Camper Health History/Physical Exam Form

(NOT NEEDED FOR FAMILY CAMPS)

Fill in all requested information. Incomplete forms cannot be processed and will be returned. Forms are due two (2) weeks before your child's session begins.

Mail to: **Camp Cherokee, c/o New York Conference of SDA, 4930 W. Seneca Tpk., Syracuse, NY 13215**

Please Print (**THIS SIDE AND TOP OF BACK PAGE TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAMINATION**).

Camper Name_____ Birth date:_____ Age _____ Sex _____ Home Phone_____

Parent/Guardian _____ Home Address_____

Business Address_____ Business/Cell Phone_____

Other Parent/Guardian_____ Home Address:_____ Home Phone_____

Business Address_____ Business/Cell Phone _____

In the event of emergency, and parent or guardian cannot be reached, notify _____ Relationship to camper_____

Address_____ Home Phone_____ Business/Cell Phone_____

Note:

This person must be a relative over 18. If someone is not a relative, a "notarized statement" authorizing that person to approve medical treatment is necessary. In the event of an injury or illness that does not require removal to a hospital, parents shall not be notified unless medical personnel's concerns dictate. When injuries or illnesses require a trip to the hospital, either the RN accompanying the camper or the camp director or their designee will notify the parents.

Health History - To be completed by **PARENT/GUARDIAN** *(give approximate date of illness or 'no" if not applicable)*

___ frequent ear infections
___ heart defect/disease
___ convulsions
___ diabetes
___ hypertension
___ psychiatric treatment
___ mononucleosis
___ sleep walking
___ bleeding/clotting
___ bed wetting
___ fainting
___ asthma

Allergies
___ hay fever ___ other
___ plants ___ insect stings
___ food:_____
_____

Diseases
__ chicken pox
__ measles
__ German measles
__ mumps

Medication Allergies:_____

Current medication (send in original container with instructions):_____

Operations or serious injuries (dates):_____ Disability of chronic or recurring illness:_____

Dietary modifications:_____ Any specific activities limited:_____

Name of dentist/orthodontist:_____ Phone:_____

Name of family physician:_____ Phone:_____

Medical Insurance

Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.

Authorization for release for information to above named insurance carrier

Signature_____ Date_____ Relationship to camper (parent, etc.)_____

Address of Insurance Company

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.

IMPORTANT - This Box Must Be Completed For Attendance

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. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine test, treatment and necessary 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 Director to secure and administer treatment, including hospitalization, for my child, as named above. The completed forms may be photocopied for trips out of camp.

Meningococcal Meningitis Vaccination Response

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response for every camper who attends camp for seven (7) or more nights. Please check one box and sign below.

__ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received:_____
Note: The vaccine's protection lasts for approximately 3 to 5 years. Re-vaccination may be considered within 3-5 years)

__ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signature of parent or guardian_____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor _____

Licensed physician to fill out back of this form