2023 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 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: $454.00 ___ Picture - $5.00 ___ CD - $10.00 (***check box & include with total below.)***

Camp #	Camp Date	Camp Selection(s)	Camp Cost	
1	July 2-9	Teen Camp		
2	July 9-16	Junior/Tween Camp		
3	July 16-23	Adventure/Diabetic Awareness Camp		
		NY Conf. Member Discount ($25)		
		Early Bird Discount ($25)**		
		Store/Offering		
		Picture/CD		
		TOTAL*		

* $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

$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 _______________
Height _________________
Weight_________________
Posture & Spine__________
Feet___________________
Teeth __________________
Blood pressure___________
Heart murmur ___________
Ears___________________

Nutrition___________________
Nose _____________________
Throat-tonsils_______________
Lungs ____________________
Eyes
Discharge ________________
Glasses__________________
Menstruation_______________
Urine ____________________

Allergy
Foods______________________
Drugs______________________
Other______________________
Abdomen____________________
Genitals_____________________
Hernia ______________________
Skin
Scabies_____________________

Athlete's foot_____________
Impetigo ________________
Infection ________________
Pediculosis ______________
Describe Current conditions (diabetic, seizures, emotional issues, etc.)________
____
____
____
____

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, restrictions or considerations):

Provider's Name (print) ____
Providers Signature ____
Address:____

License #:_______________________
Date:_____________________________
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