Dear Parent/Guardian of a Day Camper:

Welcome to Innabah's Summer Day Camp Program. Thank you for your registration to this exciting camping program. Your Day Camp Director, Counselors and I are excited that your child is coming to camp. Please read carefully the information noted below as it will answer many of your questions and share several of our concerns as well. **Please note**: Day Camp runs from Monday through Friday from 9am to 4pm.

A. **Monday Registration**: begins promptly at 9:00 am in the Day Use Picnic Area. You will need to bring with you the completed Health History Form, Authorization for Medication Form (if your child is bringing medication to camp), and Parent/Legal Guardian/Video Release Form designating who will be picking up your child each day. An Innabah Staff member or volunteer will check your camper at registration and keep any medication that the camper needs throughout the day. At registration you will be asked about items B through C.

B. **The Store**: As a part of your registration fee, $5.00 will be used to provide your child a snack each day. Additional purchases can be made after day camp at the store.

C. **Clothing**: Please remember this is a day camp experience and campers will be outdoors most of the time, so please dress for camp. Packing extra clothes and a bathing suit, towel and sun screen for each day is a great idea. Campers will be required to take off their wet swimsuits and change into dry clothes after swimming. A jacket or sweatshirt and rain gear are also good to pack just in case of cold or wet weather.

D. Please be extremely careful when driving on camp. Take any and all precautions when entering and leaving the Day Use Area as small campers are difficult to see. Also, please walk your camper to the pavilion each morning for registration.

E. Your camper will be welcomed by the Day Camp Director and/or their counselor and then begin to participate in get acquainted activities with other Day Campers. Along with a day full of activities, Lunch will be provided by the Innabah Staff.

F. **PLEASE REMEMBER:** Daily registration begins promptly at 9:00 am. Do not arrive with your camper before 8:55 am. Daily check out time is 4:00 pm. Do not arrive later than 4:00 pm for pick up.

G. **Please note that we have day camp extended hours**. If you didn't register for the extended hours, you still can. You must register **at least a week ahead of time** for this option. We have early drop off and pickup at the Farmhouse. Children can be dropped off between 7:30-8:45AM and picked up at 4:00-5:30PM.

H. If you would like to register for additional weeks of day camp, please use the enclosed form.

Thank you for your registration for Day Camp. We look forward to seeing you this summer. Please see the reverse side of this paper for directions.

God Bless You,

Christy Heflin, Director

******* Don't Miss Page 2!!!!!!!!!!!!**

DIRECTIONS to INNABAH:

Innabah is located in Chester County, one/half mile East of Route 100 at Pughtown Rd, which is just South of Route 23.

From the South, exit at the Downingtown interchange of the PA Turnpike(Exit #312) and go North on Route 100 about 8 miles to Pughtown Rd. Turn Right at the Innabah sign at the intersection of Route 100 and Pughtown Road.

From the North, follow Route 100 South to Pughtown Rd. Turn Left at the Innabah sign at the intersection of Route 100 and Pughtown Road.

MAILING ADDRESS: INNABAH
712 Pughtown Road
Spring City, PA 19475

PHONE NUMBER: (610) 469-6111

DIRECTOR: ChristyHeflin, innabahdirector@aol.com

Eastern PA Conference/United Methodist Church

HEALTH HISTORY FORM

(To be completed and signed by parent/guardian; please print or type all entries)
Completed form must be brought to camp -
PLEASE DO NOT MAIL

For Camp Use Only:
Camp #__________________

Housing_________________

GENERAL INFORMATION

CAMPER'S NAME____ GRADE COMPLETED________
(Last) (First) (MI)

Social Security #________________BIRTHDATE_____________ AGE____ SEX: M___F___ HEIGHT______ WEIGHT______

NAME OF PARENT/GUARDIAN____
(Please Circle One) (First) ____________________________ (MI) __________ (Last) _________________________

ADDRESS OF PARENT/GUARDIAN____
(Street) (City, State, Zip)

PHONE NUMBERS OF PARENT/GUARDIAN
Father/Guardian: Home-(_____)________________Work -(_____)_______________Cell -(_____)_________________________

Mother/Guardian: Home-(_____)________________Work -(_____)_______________Cell -(_____)_________________________

IN CASE OF EMERGENCY, IF PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE NOTIFY:

NAME____ RELATIONSHIP TO CAMPER__________________________

ADDRESS____ PHONE (______)_____________________

PHYSICIAN'S NAME____ **PHONE NUMBER** (_______)____________________

FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER

POLICY ID #_________________ POLICY/GROUP #______________________ POLICY HOLDER'S SSN
(This information is required since each camper is covered by limited accident and medical insurance in excess of parent's own insurance; **CAMP'S POLICY IS A SECONDARY POLICY.** PA state law prohibits duplicate payments.)

For minor illness or injury, the following medications are available to administer to campers **as needed** (based on our standing medical orders): Acetaminophen/Tylenol, Ibuprofen, Milk of Magnesia, Mylanta, Kaopectate, Diphenhydramine/Benadryl, Robitussin, Pseudoephedrine/Sudafed, Antibiotic Ointment, Caladryl, Desenex, Chloraseptic spray and lozenges, Swimmer's Ear Drops, Anbesol, Hydrocortisone Cream.

⏮ Do not administer above medications ⏮ Administer above medications

⏮ Administer above medications except ____

Signature____

CERTIFICATION AND AUTHORIZATION ***MUST BE COMPLETED FOR ATTENDANCE**

I certify that the information provided on both sides of the Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form why my son/daughter/camper should not participate in all camp activities. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical conditions, restrictions, or limitations of my child. I understand the State of PA requirement that all campers be examined by the Health Care Staff on the day of registration and give my permission for the conduct of such an examination.

My son/daughter/camper___________________________, has permission to participate in the activities associated with the summer camping program of the Eastern Pennsylvania Conference/United Methodist Church. Further, in the event of an illness or emergency, the Program Center Director or designee is authorized to act in my behalf in securing medical treatment for my child named above.

Signature of Parent/Guardian____ Date______________________

Don't Miss Page 2!!!!!!!!!!!!!!!!!!

TO GIVE APPROPRIATE CARE TO THE CAMPER WHILE HERE AT CAMP, PLEASE COMPLETE THE FOLLOWING INFORMATION ACCURATELY - THANK YOU

DATE OF CAMPER'S LAST HEALTH EXAM_______________WERE ANY PROBLEMS NOTED AT THAT TIME?___YES___NO

SINCE THE CAMPER'S LAST HEALTH EXAM, HAS HE OR SHE HAD ANY OF THE BELOW:

A serious injury requiring medical attention ___Yes ___No
Surgery or a fracture ___Yes ___No
A diagnosed infectious disease ___Yes ___No
Exposed to any communicable disease ___Yes ___No
**A physician's restriction in any physical activity ___Yes ___No
**Medication prescribed ___Yes ___No

PLEASE EXPLAIN :____

** **A physical examination may be required to participate in physically active camps.** (See camper letter) **NO Medication will be given without completed medication forms!**

Is the camper currently under a physician's care for a medical problem? (Describe)

Are all immunizations up to date?___Yes ___No Date of last Tetanus (DPT,DT,TT) Shot MUST be listed here_______________

Has the camper ever had or now have any of the following medical problems?

⏮ Asthma ⏮ Frequent ear Infections/cold /sore throats ⏮ Chicken Pox ⏮ HIV ⏮ TB
⏮ Bleeding/Clotting Disorder ⏮ Convulsions/Seizures ⏮ Diabetes ⏮ Heart Disease or Defect ⏮ Hypertension
⏮ Kidney Disease ⏮ Sickle Cell Disease ⏮ Behavioral/Emotional Problems ⏮ Other

Please explain :____________________________

Please check the following conditions that apply to the camper:

⏮ Athlete's Foot/Ringworm ⏮ Bed Wetting ⏮ Sleepwalking ⏮ Special Diet
⏮ Fainting ⏮ Motion Sickness ⏮ Hearing Impairment ⏮ Ear Tubes ⏮ Wears Glasses/Contacts
⏮ Menstrual Cramps ⏮ Stomach Upsets ⏮ Homesickness ⏮ Nosebleeds ⏮ Constipation

Please explain :____________________________

Does the camper have any of the following allergies? (Please check and describe)

ALLERGIES	Describe	Treatment
⏮ Medications	________________________________	
⏮ Seasonal/Environmental	________________________________	
⏮ Insect Stings	________________________________	
Other______________	________________________________	

FOR CAMP USE ONLY: ON-SITE HEALTH EXAMINATION

General Health Condition:

Illnesses experienced or exposed to during preceding 30 days: ____

Recommendations and restrictions (activity, diet, etc): ____

Skin Lesions/Bruising:______________________________ Other ____________________________________

Signature of Examiner ____ Date ___________________________

EASTERN PENNSYLVANIA CONFERENCE OF THE UNITED METHODIST CHURCH
Camp Innabah, 712 Pughtown Road, Spring City, PA 19475

AUTHORIZATION FOR MEDICATION ADMINISTRATION

PLEASE NOTE: **ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS MUST BE AUTHORIZED BY A PHYSICIAN/PROVIDER**. You may copy this form.

Child's Full Name ____

Reason for Medication(s) ____

If your camper must receive medication during his/her scheduled summer camping session, please complete this form and bring it along with the prescribed medication to camp with the camper. All medications and forms will be checked at camp registration on the start day of your camper's event. **NO Medication will be accepted unless his/her name is on the original prescription**. Campers using over the counter medications daily must have this form signed and brought to camp with the medication.

PRESCRIBING PHYSICIAN INFORMATION - I certify that it is imperative that the medication prescribed below be taken during this child's camping session.

(Physician's Name) **(Physician's Signature)** (Phone) (Date)

____________________ ________________________ _____________ _________

Medication Name(s) / Dosage(s)	**Time(s) : B-Breakfast, L-Lunch, D-Dinner, HS-Bedtime**
	⏮ B ⏮ L ⏮ D ⏮HS ⏮ Other_______
	⏮ B ⏮ L ⏮ D ⏮HS ⏮ Other_______
	⏮ B ⏮ L ⏮ D ⏮HS ⏮ Other_______
	⏮ B ⏮ L ⏮ D ⏮HS ⏮ Other_______

PARENT AUTHORIZATION

I, ______________________________________ give my consent to the Health Care
(Name of Parent/Guardian)
Staff to administer the above medication(s) to my child/camper__________________________
(Name of Camper)
during their time at Camp Innabah from ____________________ through __________________
(Starting Date) (Closing Date)

(Signature of Parent/Guardian) ______________________________ Date _________________________

THIS SECTION COMPLETED BY HEALTH CARE STAFF ONLY

⏮Permission form completed ⏮Safety type container ⏮Original prescription label
⏮Name of this child is on the label ⏮Date on label is current ⏮ OTC, original container and current
⏮Name of drug, dose, and frequency of administration is on label
⏮ Inhaler and/or Epi-Pen with camper (either with individual or counselor)

(**Health Care Staff Approval**) ____________________________________