

Butman Methodist Camp

2018 Camper Registration Form

Mail to: **Camp Registrar** Phone: 325-846-4212
158 County Rd. 674 Fax: 325-846-3231
Merkel, TX 79536 Email: camp@butmancamp.org
Web Site: www.butmancamp.org

For office use only

Check # _____ \$ _____ \$ _____
 Amount of check this camper

Check From: _____

Check # _____ \$ _____ \$ _____
 Amount of Check this camper

Check From: _____

Registering For: Please check all Camps that apply:

Camper Fees Postmarked on or before...	February 23 st	April 15 th	After April 15 th
<input type="checkbox"/> New Dawn II (July 25-29) (for intellectually challenged adults-18+)	\$270.00	\$285.00	\$298.00

*****Please see www.butmancamp.org for costs, dates, and Camp Directors for each camp*****

Registrations must be completed and signed by the parent/guardian. Many churches financially help their youth pay for camp. Please contact your home church about this possibility. Please have pastor or appropriate staff person sign registration form. The signed and completed Medical Form and registration fee must accompany the Registration Form, or forms will be returned for completion.

Please Print Legibly

Please Print Legibly

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Camper Name _____
 First (goes by) _____ Middle Initial _____ Last _____

Home Address _____
 Street or Box Number _____ City _____ State _____ Zip _____

Home Ph# (____) _____ Cell # (____) _____ **Camper e-mail** _____

School Grade Entering Fall 2018 _____ Age at Camp _____ Birth Date _____ Gender ___ (M) ___ (F)

What Church did you come to camp with? _____ Phone# (____) _____

Church Address _____
 Street or Box Number _____ City _____ State _____ Zip _____

Pastor's Name _____ Pastor's Signature _____
 (Please print)

Parent/Guardian/Mother _____ **Parent/Guardian/Father:** _____

Address _____ Address _____
 (If different from Camper) (If different from Camper)

Home Ph# (____) _____ Home Ph# (____) _____

Work Ph# (____) _____ Work Ph# (____) _____

Cell Ph# (____) _____ Cell Ph# (____) _____

Parent/Guardian Email: _____

Emergency Contact: _____ **Phone #** _____

Relationship to Camper: _____ **Who will pick up camper** _____

Does camper have an incarcerated **parent/loved one**? Yes No

Name of incarcerated parent/loved one _____

Roommate Preference (1 **only** please) _____
 (Roommate preference not guaranteed. Roommate preference not available for campers registered onsite.)

Camp Activities at **Butman Methodist Camp** may include but are not limited to: swimming, hiking, sports, water slide, group games, Ropes Course and Climbing Wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental to the camp setting and will hold the NWTX Conference, Butman Methodist Camp and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Butman Methodist Camp & Retreat Center to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, or on the camp's web site.

Custodial Parent/Guardian's Signature _____ **Date** _____

Please Note: All camp fees include a \$10.00 nonrefundable registration fee.

Camper Medical Form

Camper Name: _____ **Camp(s) Registering For:** _____

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Immunization History: Please record the date (month/year) of basic immunizations and most recent boosters.

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – <i>Haemophilus influenzae</i> type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Hep A- hepatitis A		
MCV (Meningococcal Vaccine)		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Food Allergies
		Other Allergies

Does your child have Asthma? Yes No

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions or special requests _____

Activities to be encouraged or limited _____

Current medications: PLEASE FILL OUT ATTACHED FORM.

COMMENTS: Please list any special circumstances that might affect how the camper relates to others at camp. Examples: special dietary needs, short attention span, family or personal circumstances, etc.

For Females: Has this person begun menstruation? ____ yes ____ no If not, has she been told about it? ____ yes ____ no

If so, is her menstrual history normal? ____ yes ____ no Special Consideration? _____

To the Best of My Knowledge _____

is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility. **I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

Custodial Parent/Guardian Signature _____ **Date** _____

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company _____

Policy# _____ Group# _____

Insurance Address & Phone # _____

Family Physician Name & Phone # _____

CAMP NEW DAWN II HEALTH EXAMINATION FORM

RETURN TO: Butman Camp Registrar

158 CR 674

Merkel, TX 79536

Please have parent/guardian and physician complete appropriate sections of this form **in full** before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Camper Name: _____ Date: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

***This section must be filled out before form is considered complete.**

- Is camper on a special diet? ___ Yes ___ No Explain _____
- Is camper on any special medicine? ___ Yes ___ No Explain _____
- Is camper on any new medication? ___ Yes ___ No Explain _____
- Is medicine being sent by parent/guardian? ___ Yes ___ No Explain _____
- Restrictions on swimming, diving? ___ Yes ___ No Explain _____
- Restrictions on strenuous activity? ___ Yes ___ No Explain _____
- Is camper able to dress self? ___ Yes ___ No Explain _____
- Is camper able to sleep in an upper bunk? ___ Yes ___ No Explain _____
- Is camper able to talk? ___ Yes ___ No Explain _____
- Does camper walk well? ___ Yes ___ No Explain _____
- Is camper an early riser? ___ Yes ___ No Explain _____
- Does camper wet the bed? ___ Yes ___ No Explain _____
- Does camper smoke or chew tobacco? ___ Yes ___ No Explain _____
- Is camper able to read? ___ Yes ___ No Explain _____
- Does camper have incontinence problems? ___ Yes ___ No Explain _____
- Is camper a sleepwalker? ___ Yes ___ No Explain _____
- Does camper wear protective garments (i.e. Depends) ___ Yes ___ No Explain _____

Camper's T-Shirt Size S M L XL XXL

Other _____

	Totally Independent	Partially Independent	Dependent
Brush Teeth			
Bathing			
Dressing			
Eating			
Toilet Usage			

PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and 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 director, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Parent/Guardian Signature: _____ **Date:** _____

MEDICAL EXAMINATION
To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. **You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below.** Examinations are necessary for determining fitness/ability to engage in all activities.

CODE: S – Satisfactory U - Unsatisfactory (Explain) O - Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes _____ Extremities _____

Glasses _____ Posture (spine) _____

Ears _____ Skin _____

Nose _____ Allergy-Please specify: _____

Throat _____

Teeth _____

Heart _____

Lungs _____ General Appraisal: _____

Abdomen _____

Hernia _____

*(For girls and women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

Comments: _____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician Signature: _____ Date: _____

Address: _____ Telephone: () _____

Camper's Name: _____ Date Examined: _____ Cabin # _____ Year: _____