

2009 CHILDREN'S CAMP
C.I.T. Application
'ROME – Paul and the Underground Church'



Duties of a C.I.T.

All staff, including C.I.T.'s commit to serving from 10 a.m. on August 8, 2009 to 10 a.m. August 15, 2009. There is an all-staff training/orientation at 3 p.m. August 8th. Depending on how cleanup goes, some staff may be allowed to leave Friday night, August 14th. Breakfast will be served for those who remain until Saturday morning.

A C.I.T. serves at the discretion of the camp director, and may be transferred from one job to another as needed. Some areas where a C.I.T. might serve are: assisting the camp director/camp registrar with registration, assisting cabin counselors, assisting the kitchen workers, or helping set-up/break down from an event. No contract is formed between Camp Wakonda and a C.I.T., so a C.I.T. may resign at any time or may be dismissed at any time.

Personal Requirements

- Applicant must be between the ages of 16 (must have attained his/her 16th birthday by August 8, 2009) and 17 (must NOT have attained his/her 18th birthday by August 8, 2009).
- Applicant must have attended a local Church of the Nazarene at least 10 of the 14 Sundays between May 2, 2009 and August 8, 2009, inclusive).
- Applicant must receive his/her Pastor's approval.

First Name: _____ Last Name _____

Gender: ___ M ___ F

Date of Birth: _____ I will be _____16 _____17 on August 8, 2009

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Email: _____

Home Church: _____

Mother's Name: _____ Father's Name: _____

Legal Guardian (if different from above): _____

Emergency Contact Number (if different from home phone) _____

PASTOR :

I certify that I am this applicant's pastor, and that I approve of his/her enrollment in the Camp Wakonda C.I.T. Program

Pastor's Signature

Pastor's Printed Name

Church

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the application. If a copy is not available, a physical examination (using the Medical Evaluation section of this form) must be performed by a licensed* healthcare practitioner prior to arrival at camp. If your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury in the last 18 months, the medical evaluation (physical examination) must have been conducted within the last 12 months.

***Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for Camp Wakonda purposes when such practitioners may perform physical examinations within their legally prescribed scope of practice.**

Please note: If any C.I.T. shows up for camp without proper medical paperwork, he/she will be refused admittance.

PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

I give permission for full participation in Camp Wakonda C.I.T. Program, subject to limitations noted herein.

I certify that I am the parent/legal guardian of the camper. In case of emergency, I understand every effort will be made to contact me (or, my spouse or next of kin, if participant is an adult.). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult). I will be responsible for any and all costs of medical attention and treatment.

Date _____ Signature of parent/guardian or adult _____

Check all items that apply, **past or present**, to your (child's) health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants _____ Yes _____ No

Explain: _____

GENERAL INFORMATION:

ALLERGIES: Food, medicines, insects, plants _____ Yes _____ No

Explain type of reaction: _____

Does your child have an Epi-pen? _____

	Yes	No		Yes	No		Yes	No
**Asthma	___	___	Diabetes	___	___	High blood pressure	___	___
Cancer/leukemia	___	___	Heart trouble	___	___	Kidney disease	___	___
Convulsions/seizures	___	___	Hemophilia	___	___	ADHD	___	___

**Does your child use a "rescue" inhaler? _____

**Should he/she carry it with them at all times or can it be kept with the nurse? _____

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at camp: _____

C.I.T.'s Name _____ Age _____

List any medications to be taken at camp: _____

_____ dose _____ frequency _____

_____ dose _____ frequency _____

_____ dose _____ frequency _____

_____ dose _____ frequency _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, playing sports, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

My child may be given the following medicine at the discretion of the nurse if the situation warrants. (If not indicated, you will be called prior to your child receiving any over-the-counter medications.) The nurse will have these available. If your child takes these medications regularly, please bring your child's own medicine.

Acetaminophen (Tylenol) ___ Yes ___ No

Ibuprofen (Advil) ___ Yes ___ No

Dyphenhydramine (Benadryl) ___ Yes ___ No

Dextromethorphan (cough suppressant) ___ Yes ___ No

Bismuth Subsalicylate (Pepto-Bismol) ___ Yes ___ No

C.I.T.'s Name _____ Age _____

MEDICAL EVALUATION

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one week of camp that may include sleeping on the ground and participating in strenuous activities, such as vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn	N	Abn	N	Abn		
Growth development	___	___	Teeth	___	___	Genitalia	___	___
Skin	___	___	Cardiopulmonary system	___	___	Musculoskeletal	___	___
HEENT	___	___	Hernia	___	___	Neurobehavioral	___	___

Explain: _____

Limitations

Activity restrictions _____

Diet restrictions _____

Signature _____ Date _____
Licensed health-care practitioner*

Address _____ Phone _____

City, State, Zip _____

*** Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for Camp Wakonda purposes when such practitioners may perform physical examinations within their legally prescribed scope of practice.**