

Registration and Application Form for 2010 Summer Program New Hope Camp and Conference Center, Inc.

www.newhopeccc.org

How to Register:

1. **Signatures are mandatory on registration and health form. **
2. Complete all information on this form. **One per child.**
3. Complete Health Form on reverse. This is required to guarantee registration for camp.
4. Make \$75.00 deposit check payable to NHCCC for **EACH** camp session.
5. Mail check, registration form, and health form to:

New Hope Camp and Conference Center, Inc.

Camp Registrar, 4805 Hwy 86, Chapel Hill, NC 27514

info@newhopeccc.org

phone: 919-942-4716 fax: 919-942-3266

For Office Use Only

Date Received _____

Amount Paid _____

Scholarship _____

Discount _____

T-Shirt _____

Camper Name _____

Male [] Female [] Birthdate ____/____/____

Grade **2009-2010** _____ Camper Home Phone# _____

Parent Email _____

Address _____

City _____

State _____

Zip _____

Church Membership _____ (church name)

**Camper must be a member of the Church of Reconciliation, Hawfields Presbyterian Church, Hillsborough Presbyterian Church, New Hope Presbyterian Church, University Presbyterian Church, or Westminster Presbyterian Church to receive Presbyterian Discount.

Camp T-shirts - Please circle the correct size: \$12.00

Youth: M L XL Adult: S M L XL

Parent 1's Name _____

Parent 2's Name _____

Parent 1's Day Phone _____

Parent 2's Day Phone _____

Parent 1's Evening Phone _____

Parent 2's Evening Phone _____

Parent 1's Cell Phone _____

Parent 2's Cell Phone _____

Camper Resides With _____

Have you attended NHCCC before? (circle one) **yes** **no**

Camp Session and Dates: _____

How did you hear about Camp at New Hope Camp and Conference Center?

Brochure Friend Newspaper Website
Poster/Sign Church Other

Camp Cost	\$ _____
T-Shirt	\$ _____
Less Discount**	\$ _____
Total	\$ _____
Amount Enclosed	\$ _____
Balance Due	\$ _____

AS A CAMPER, I UNDERSTAND AND WILL ABIDE BY THE BEHAVIOR POLICY DESCRIBED IN THE CAMP BROCHURE. CAMPERS WHO VIOLATE THIS POLICY MAY EXPECT TO HAVE THEIR PARENTS NOTIFIED, AND FURTHER, MAY BE SENT HOME. AS A PARENT, I UNDERSTAND THE BEHAVIOR POLICY AND AGREE TO PICK MY CHILD UP PROMPTLY IF SUMMONED BY CAMP MANAGEMENT AS A RESULT OF MY CHILD'S MISBEHAVIOR OR VIOLATION OF RULES AND POLICIES.

****CAMPER SIGNATURE** _____

DATE _____

****PARENT SIGNATURE** _____

DATE _____

Circle Payment Method: Check Credit Card **Yes, please automatically charge my credit card for each payment due date.**

MC/VISA # _____ EXP: _____ Amount to be Charged \$ _____

Signature of Card Holder: _____ Print Name _____

HEALTH FORM

HEALTH FORM MUST BE MAILED IN WITH REGISTRATION. CHILD MAY NOT ATTEND CAMP UNLESS FORM IS COMPLETED.

DATES OF CAMP ATTENDANCE: _____

NAME _____ BIRTH _____
LAST FIRST MI

ADDRESS _____
STREET CITY STATE ZIP

GENDER M F

PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ WORK _____ CELL _____

2ND PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ WORK _____ CELL _____

EMERGENCY PHONE IF ABOVE CANNOT BE CONTACTED _____ NAME _____

INSURANCE COMPANY _____ Policy # _____

INSURANCE COMPANY PHONE NUMBER _____

AUTHORIZATION

(MUST BE COMPLETED FOR ATTENDANCE)

I UNDERSTAND THAT CAMP PROGRAMS ARE NOT RISK-FREE. I GIVE PERMISSION FOR MY CHILD TO ATTEND SUMMER CAMP AND PARTICIPATE IN ALL PHASES OF CAMP ACTIVITIES, INCLUDING TRIPS AS RELATED TO CAMP PROGRAM. I UNDERSTAND THAT THE CAMP MAY USE PHOTOGRAPHS AND/ OR VIDEOTAPES OF MY CHILD FOR PUBLIC RELATIONS. I UNDERSTAND THAT THE CAMP IS NOT RESPONSIBLE FOR LOSS OF VALUABLES.

I CERTIFY THAT THE INFORMATION HERE IS CORRECT AND GIVE PERMISSION FOR MY CHILD TO BE TRANSPORTED IN PRIVATELY OWNED VEHICLES IF NECESSARY FOR APPROVED OUT-OF-CAMP ACTIVITIES OR EMERGENCY TRANSPORT.

FURTHER, I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP MANAGEMENT TO PROVIDE ROUTINE HEALTH CARE; TO ADMINISTER MEDICATIONS; TO ORDER X- RAYS; ROUTINE TESTS; TREATMENT; TO RELEASE ANY MEDICAL RECORDS NECESSARY AND TO PROVIDE OR ARRANGE NECESSARY RELATED TRANSPORTATION FOR MY CHILD. I UNDERSTAND THAT IN AN EMERGENCY EVERY EFFORT WILL BE MADE TO CONTACT ME. IF I CANNOT BE REACHED, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY CAMP MANAGEMENT TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD.

I HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS THE AGENTS, EMPLOYEES, OFFICERS, AND ENTITIES OF NEW HOPE CAMP AND CONFERENCE CENTER, INC. FROM ANY AND ALL CLAIMS RESULTING FROM INCIDENT, INJURY OR LOSS ASSOCIATED WITH, OR ARISING FROM OUR USE OF THE NEW HOPE CAMP AND CONFERENCE CENTER FACILITY.

SIGNATURE OF PARENT/GUARDIAN IN INK _____

PRINTED NAME _____

IS THERE ANYONE LEGALLY RESTRICTED FROM SEEING THE CAMPER? NAME AND DESCRIBE. PLEASE ENCLOSE PHOTO IF AVAILABLE, LABELED WITH NAME ON BACK.

DOCTOR _____ PHONE _____

DATE OF LAST EXAMINATION _____ CAMPER UNDER DOCTOR'S CARE _____
 FOR THESE CONDITIONS Must Be Within 24 Months of Chosen Camp Start Date

CURRENT MEDICATIONS (MUST BE IN ORIGINAL CONTAINER WITH LABEL & CORRECT DOSAGE)
 List all and indicate whether they are taken at home or at camp.

PARENT/GUARDIAN MUST PROVIDE ANY ADDITIONAL INFORMATION WHICH THE CAMP SHOULD BE AWARE OF REGARDING CAMPER'S BEHAVIOR, PHYSICAL, EMOTIONAL AND MENTAL HEALTH. ATTACH PAGES IF NEEDED.

ANY HEALTH OR DIET RESTRICTIONS WHILE AT CAMP? _____

HEALTH HISTORY (PLEASE LIST DATES)

- | | | |
|----------------------------------|---------------------|--|
| _____ Frequent Ear Infections | _____ Mononucleosis | ALLERGIES:
_____ Hay Fever |
| _____ Heart Defect/Disease | _____ Diabetes | _____ Poison Ivy |
| _____ Psychiatric Treatment | _____ MMR | _____ Insect Stings |
| _____ Bleeding/Clotting Disorder | _____ Chicken Pox | _____ Penicillin |
| _____ Hypertension | _____ Hepatitis A | _____ Other Drugs |
| _____ Convulsions | _____ Hepatitis B | _____ Other Allergies
(Please List) |
| _____ Asthma | _____ Epilepsy | |
| _____ Bedwetting | _____ Sleepwalking | |

****If this camper is diagnosed with Attention Deficit Disorder and/or Hyperactivity Disorder, please attach a sheet describing the camper's routine, medications and schedule, and what methods have been effective in helping this camper manage in a structured environment. Please list all medications for ADD/ADHD including those taken at home and discuss with your doctor the proper dose for the hot and highly structured camp environment.****

ADDITIONAL ALLERGY INFO _____

HAS CAMPER EVER HAD OPERATIONS/SERIOUS INJURIES _____

IMMUNIZATION HISTORY (OR ATTACH COPY OF DOCTOR'S SHOT RECORD) **REQUIRED***

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria	1	1
Pertussis DPT (Whooping Cough)	2	2
Tetanus	3	3
Tetanus Diphtheria or TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salik)		
MMR		
Hepatitis A		
Hepatitis B		
Other		
Tuberculin Tests given most recently		