

YMCA OF ORANGE COUNTY - CAMP OAKES REGISTRATION

Please return completed packet no later than June 1, 2024

SESSION: Camp Oakes - August 4th - 10th, 2024

Age Group	<input type="checkbox"/> Camper (ages 8-14) <input type="checkbox"/> Counselor-In-Training "CIT" (ages 15-17)			
T-Shirt Size	<input type="checkbox"/> Child Size	<input type="checkbox"/> Adult Size	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL	

CHILD INFORMATION

Child's Last Name	Child's First Name	Date of Birth	Gender	Phone #
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-Binary	
Home Address		City	State	Zip Code
Mailing Address (if different from Home Address)		City	State	Zip Code

PARENT / GUARDIAN INFORMATION

RESPONSIBLE PARTY INFORMATION - The "Responsible Party" is the parent or legal guardian enrolling the child and primarily responsible for payment fees, signing releases, authorizing individuals to sign in/out the child.

Responsible Party's Last Name	Responsible Party's First Name	Date of Birth	Relationship to Child	Home Phone #
Email Address			Cell Phone #	
Home Address	<input type="checkbox"/> Check if same as child	City	State	Zip Code
Occupation	Company	City	Work Phone #	
Other Parent/ Guardian Last Name	Other Parent/ Guardian First Name	Date of Birth	Relationship to Child	Home Phone #
Email Address			Cell Phone #	
Home Address	<input type="checkbox"/> Check if same as child	City	State	Zip Code
Occupation	Company	City	Work Phone #	

FOSTER / AGENCY INFORMATION (if applicable)

Foster/Other Agency Name	Foster/Other Agency Contact Person	Foster/Other Agency Phone #	Foster/Other Agency Email	CFS Region

CABIN-MATE REQUEST*

Requested Cabin-mate Name:	Requested Cabin-mate Age:

*The YMCA will make every attempt to honor one cabin-mate request per camper for children of similar age and gender.

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EMERGENCY CONTACTS

EMERGENCY CONTACTS - The following individuals have my **unrestricted** permission to sign my child out from the program and can be contacted in an emergency if/when I cannot be reached.

MINIMUM OF TWO REQUIRED IN ADDITION TO PARENTS/GUARDIANS (on page 1).

Emergency Contact #1		Relationship to Child
Cell Phone #	Home/Work Phone #	Email Address
Emergency Contact #2		Relationship to Child
Cell Phone #	Home/Work Phone #	Email Address
Emergency Contact #3		Relationship to Child
Cell Phone #	Home/Work Phone #	Email Address
Emergency Contact #4		Relationship to Child
Cell Phone #	Home/Work Phone #	Email Address
Emergency Contact #5		Relationship to Child
Cell Phone #	Home/Work Phone #	Email Address

RESTRICTED PICK-UP

RESTRICTED PICK-UP - The following individuals are **restricted** from signing my child out from the program due to a court-issued restraining order. **A certified copy of the official court documentation must be kept in child's file.**

Name:		Date of Court Order:	
Name:		Date of Court Order:	

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CHILD QUESTIONNAIRE

CHILD QUESTIONNAIRE - Please answer the questions below thoroughly and honestly. This information will be shared with your child's counselor to help facilitate the best possible camp experience.

What does your child prefer to be called?

Who else lives at home?

Has your child been to a resident (overnight) camp before? If so, when and where?

Does your child get along easily with friends?

Does your child ever wet the bed?

If yes, what methods have you found effective in preventing it?

Does your child ever sleepwalk?

If yes, what methods have you found effective in preventing it?

Does your child have nightmares?

If yes, what methods have you found effective in preventing it?

Has your child ever run away from home?

How does your child feel about going to camp?

How does your child spend his/her free time?

What skills do you hope your child might get out of camp?

Does your child have friends or siblings coming to the same camp?

Please provide any information that will assist counselors in ensuring that your child will have a positive experience at camp.

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RELEASE FOR ADMINISTRATION OF MEDICATION

Prescription & Non-Prescription

CHILD'S NAME	PARENT/GUARDIAN'S NAME	PARENT/GUARDIAN'S PHONE #

The law allows certain persons to assist in carrying out a physician's recommendation. It is understood that the YMCA Program is not legally obligated to administer medication to my child or ward. Therefore, I agree to hold the YMCA Program, its personnel and employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

All medication MUST be in the original container and labeled with the child's name and dispensing instructions. Medication will be dispensed as labeled on the container, no modifications will be accepted.

Please list all medications (including over-the-counter, prescription and non-prescription drugs) that the participant is ROUTINELY taking. Please provide enough medication to last the entire duration of the camp session.

Please be as specific as possible to ensure proper administration of medications. Use other side for further explanation. Use additional pages if more than four medications are needed.

- Medication: This camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp.

Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Name of Medication	Date Started	Reason for Taking	Time of Day Given	Amount or Dose	How It Is Given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. *Cross out those the camper should not be given.*

- | | | |
|----------------------------|-------------------------------------|---|
| Diphenhydramine (Benadryl) | Acetaminophen (Tylenol) | Pseudoephedrine (Sudafed) |
| Calamine lotion | Ibuprofen (Advil, Motrin) | Phenylephrine (Sudafed PE) |
| Topical antibiotic cream | Antihistamine/allergy medicine | Guaifenesin (Robitussin) Dextromethorphan (Robitussin DM) |
| Aloe/Sunscreen | Chlorpheniramine maleate | Lice shampoo or scabies cream (Nix, Elimite) |
| Generic cough drops | Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate (Pepto-Bismol) |
| Hydrocortisone 1% cream | Chloraseptic (Sore throat spray) | |

Parent/Guardian Signature
Parent/Guardian Name
Date

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american **CAMP** association®

Return this completed packet by email to the Camp Oakes Directors no later than June 1st, 2024.

CampOakes@ymcaoc.org

If you have any questions, call or email the Camp Oakes Directors at 714.508.7671 (voicemail only, your call will be returned by a Camp Director within 2 business days.)

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete pages 5, 6 and 7 (CAMPER HEALTH HISTORY FORM) of this form and make a copy.
- 2) Send the original, signed to camp by the requested date.
- 3) Complete the top of page 8 (PHYSICIAN PHYSICAL FORM) and provide the copy of CAMPER HEALTH HISTORY FORM with page 8 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return page 8 (PHYSICIAN PHYSICAL FORM) to camp by the requested date.

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:
Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:
Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:
Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet. This camper is lactose intolerant. This camper is gluten intolerant.
 Other, please explain in space.

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name _____
First _____ Middle _____ Last _____
(For Camp Use) Cabin or Group _____
(For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: _____

First

Middle

Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | | | |
|--|--|--|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

- | | |
|---|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....
<small>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)</small> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s) - REQUIRED: _____	Phone: (____) _____
Name of dentist(s): _____	Phone: (____) _____
Name of orthodontist(s): _____	Phone: (____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA PHOTO/AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

Consent & License. For my participation in activities to be conducted by the YMCA of Orange County or any of its chartered member associations in the United States (collectively "the Y"), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating third-parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived, adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third-parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any particular products or services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All works shall belong to YMCA of Orange County;
- The Y has no duty of confidentiality regarding any licensed uses;
- YMCA of Orange County shall exclusively own all known or later existing rights to the uses throughout the world;
- The Y and collaborating third-parties may use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third-parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Signature: _____

Date: _____

Printed Name: _____

Age: _____

Address: _____

I am the parent or legal guardian of _____. I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: _____

Printed name: _____



YMCA PARTICIPANT SWIM ABILITY QUESTIONNAIRE

The YMCA of Orange County has planned to take your child swimming this summer. This may include swimming at a YMCA pool, the local beach or a swim park.

In order for the YMCA director and teachers to provide a safe swim environment for your child the YMCA requests that you fill out this brief questionnaire on your child's swim capabilities.

Child's Name: _____ Child's Camp/School Site: Camp Oakes

PLEASE CHECK THE APPROPRIATE BOX:			
Can your child jump feet first in to the water at a depth of 5 feet or deeper?	YES	NO	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your child tread water for 10 seconds?	YES	NO	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without grabbing the pool wall, can your child swim the front stroke with the ability to have their face in the water and take comfortable breaths?	YES	NO	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your child swim half the length of the pool?	YES	NO	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your child roll on to their back and float for 10 seconds?	YES	NO	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please fill out a separate questionnaire for each of your children in the program.

If you have any additional comments or remarks about your child's swimming capabilities please list them here: _____

Date: _____

Parent's Name: _____

Parent's Signature: _____



YMCA OF ORANGE COUNTY

TRANSPORTATION PASSENGER PROFILE	
Participant's Name: _____	Phone: _____
Site/Location Name: <u>Camp Oakes</u>	Branch: <u>Overnight Camp</u>
Sex: <i>Male</i> <input type="checkbox"/> <i>Female</i> <input type="checkbox"/>	Height: _____ Hair Color: _____
Birth Date: _____	Age: _____ Eye Color: _____
Session Date: <u>August 4th - 10th, 2024</u>	

For identification purposes, please attach a recent color photo below or include one as an attachment when returning your packet.

*NOTE: Scanned photos must be scanned in color.

