Cornerstone Evangelical Baptist Church
801 Silver Ave, San Francisco, CA 94134
(415) 587-7242 www.cebc.net

CEBC YOUTH CAMP
June 25 - July 1, 2023

Koinonia Conference Grounds* 1605 Eureka Canyon Road* Watsonville, CA 95076 * (831) 722-1472
Registration Cost: $580 paid by June 17, 2023
Please make checks payable to: *Cornerstone Evangelical Baptist Church*

Name	Gender M / F
Address	Cross Streets
City	Zip
Telephone	Birth date:
Grade('22-'23 school year): 6th 7th 8th 9th 10th 11th 12th	Friend of:
School	
In case of emergency, please notify: Father's Name:	Mother's Name:
Daytime Phone #:	Daytime Phone #:
Cell Phone #:	Cell Phone #:
Medical Insurance Co:	Medical Policy #:

PARENT/GUARDIAN CONSENT AND AUTHORIZATION FOR HEALTH CARE: This health history is correct and the camper described has permission to participate in all activities, which may include the high ropes course, except as noted by me and/or the examining physician. I will not hold Koinonia Conference Grounds, Cornerstone Evangelical Baptist Church or its agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to participate in any offsite activities during camp and to be transported to and from any offsite activities, including emergency situations (if any) by authorized vehicles. Koinonia Conference Grounds and Cornerstone Evangelical Baptist Church has my permission to obtain a copy of my child's health record from the providers who treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Koinonia Conference Grounds and Cornerstone Evangelical Baptist Church Staff. I give permission to the physician selected by Koinonia Conference Grounds and Cornerstone Evangelical Baptist Church to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child. This form may be photocopied. By signing below, I give permission to Koinonia Conference Grounds and Cornerstone Evangelical Baptist Church to use video or photography of me or my family members for promotional purposes.

I have completed the Health Care Information on the back of this form. **Initial: ________________**

Parent/Guardian Signature: ____ **Date: ________________**

Note: On Sunday, June 25th, drop off luggage at 801 Silver Ave. by 2:00pm
On Saturday, July 1st, your child will be driven to 801 Silver Ave. (Cafetorium) 1:30pm-2:00pm

Special Circumstances - *Requires Camp Director's concurrence/approval*
(Including: late arrivals and early departures)

Camp Director's Signature

Date

***** For Office Use Only *****

Payment Method: ☐ Check Amt. _______ ☐ Cash Amt.__________ Date Comments/Notes

Scholarship Amt.: Approved by: Date

The information provided on this form will be used to brief kitchen staff about nutritional needs, educate Cabin Leaders & the Camp Director about camper needs, and provide Healthcare Staff with background about your child. Receiving adequate information at least two weeks prior to your child's arrival is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly.

HEALTH HISTORY: To be completed and signed by parent or guardian. Please keep a copy for your records and to record changes in your child's health status. Please notify Koinonia Conference Grounds in writing if there are any changes.

ALLERGIES: Please mark those that apply to this camper.

○This camper has no known allergies.
○This camper has an allergy to the following food(s): ____
Does this cause anaphylaxis? ○Yes ○No ○Unknown

Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed): ___________
____

NUTRITION: We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to this camper. Please call if you have any questions.

○This camper eats a regular, varied diet
○This camper is lactose-intolerant. *(Our expectation is that the camper will bring his/her own supply of products (such as Lactaid) and will contact the nurse or health coordinator when the supplement is needed.)*

CHRONIC CONCERNS: Please mark all that pertain to this camper and provide information about supportive health care.

○This camper has no chronic health concerns and is capable of full participation in this program.
This camper has the following chronic health concern(s):

○Asthma	○Headaches	○Sleepwalking	○Diabetes
○Hearing Difficulties	○Menstrual Cramps	○Frequent ear infections	○Bedwetting
○Bee Sting Allergy	○Seizure Disorder	○Surgical History	○Fainting
○Fears/Phobias	○Other (please describe):___________________________________		

Please provide information about supportive health care needed for each marked item (if any):_________________________
____

If *Surgical History* is marked above, please explain: Date of Surgery: __________Type of surgery: _____________________________

Are all symptoms resolved? ○Yes ○No - Please explain: ____

Is the camper cleared by parent and physician for active camp participation? ○Yes ○No Record of immunizations____________
____ Date of last Tetanus shot: ___________

Camper's Physician: ______________________________________ Office Phone: (_____) ____________________

MEDICATIONS: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes.

○This camper does not take any medication.
○This camper takes daily medication:

1. Medication: ______________________________ Reason for Taking: ___________________________________

Dose Taken: _____________________________ How often each day? ____________________________________

MEDICATIONS (continued):
The following medications, stocked in the Gauze Pad/Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used. Please cross-out any medicine your camper ***should not*** be given:

Acetaminophen (Tylenol)	Aloe	Antacid	Bismuth Chewable Tablets
Calamine Lotion	Chamomile Tea	Cough Drops	Diphenhydramine (Benadryl)
Dramamine	Guaifenesin DM (Cough Med)	Hydrocortisone Cream	Ibuprofen (Motrin)
Insect Repellant	Iodine Swabs	Kaopectate/Anti-Diarrheals	Nix
Pepto Bismol	Pseudoephedrine	Tinactin	Triple Antibiotic Cream

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Please mark YES or NO for each statement.

1. This camper has been diagnosed with ADD or ADHD .... ○Yes ○No
2. This camper has psychiatric diagnosis such as depression, OCD, panic/anxiety disorder .... ○Yes ○No
3. This camper has an emotional health concern .... ○Yes ○No
4. During the past academic year, this camper has seen or is currently seeing a professional to address mental/emotional health concerns. .... ○Yes ○No
   If yes, please specify: ____
5. This camper has had a significant life event that continues to affect the camper's life .... ○Yes ○No
   If yes, please provide written information about the event.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide additional information about your child's health which may have been neglected on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our active camp program.