

**SOUTHERN HILLS LEADERSHIP PROGRAM
SUMMER CAMP APPLICATION**

Please mail completed application along with the check to: Southern Hills, Inc.
25022 Luna Bonita Dr.
Laguna Hills, CA 92653

Name of camper _____ DOB _____

Address _____

City: _____ Zip Code: _____ Grade entering next fall: _____

Home telephone (____) _____ - _____ Parent's Email _____

Father's name: _____ Daytime telephone: _____

Mother's name: _____ Daytime telephone: _____

I heard about the Camp from: _____

My daughter participates in a leadership club during the school year: Yes No

If yes, the name of the club is: _____

My daughter knows how to swim: Yes No

My daughter would like to participate in the following activities:

drama dance art choir/music swimming basketball canoeing hiking
 volleyball low ropes high ropes

Participation Agreement: I understand that any photographs or videos taken of my daughter during the camp activities may be used in future camp promotional materials. Should I not want my daughter's picture used in any way, I will inform Southern Hills, Inc. in writing. The camp is not responsible for lost and/or damaged personal property. I agree to abide by camp rules regarding phone calls, visitors, etc. I also agree to hold the organizers harmless from liability on account of injuries suffered by my child. Any claims for injuries shall be limited to the insurance coverage available for camp purposes. My Insurance Company and current coverage is:

I certify that I have read the Participation Agreement and agree to its terms.

Parent/Guardian signature: _____ Date: _____

To preserve our standards, the number of campers is limited. The Board of Southern Hills Inc. reserves the right to refuse admission or request withdrawal of any camper if it is deemed necessary to protect the program's welfare. Campers without complete application materials or health information will not be allowed in the program.

Southern Hills Leadership Program
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HEALTH AND ACTIVITY CONSENT FORM

Please note: Campers cannot participate in this program if they are sick seven days before camp, or exposed to someone with a known infectious/communicable disease (i.e. H1N1) 1-2 weeks prior to the activity.

IN CASE WE NEED TO REACH YOU, PLEASE PROVIDE CONTACT INFORMATION:(Print)

Camper Name: _____ Birth date: _____ Age: _____
Home Phone: _____ Home Address: _____
Cell Phone Mom: _____ Work Phone: _____
Cell Phone Dad: _____ Work Phone: _____

IF I AM NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Phone: _____
Name: _____ Phone: _____

HEALTH HISTORY (PLEASE CHECK &/OR GIVE APPROXIMATE DATE)

Allergies:	Diseases:	Diabetes
Hay fever/seasonal _____	Chicken pox _____	_____
Insect/Bee stings _____	Bleeding/Clotting _____	Heart defect/disease _____
Drugs _____	Asthma _____	Convulsions _____
Tetanus vaccination: year immunization: _____	Year last booster: _____	

Other Medical Concerns/Serious Injuries/Operations): _____

Does camper have any activity limitations or restrictions(include dietary/food allergies): _____

PHYSICIAN NAME: _____ **PHONE:** _____
INSURANCE CARRIER: _____ **POLICY/GROUP NO:** _____

POLICY REGARDING NOTIFICATION OF PARENT OR GUARDIAN BY HEALTH STAFF

As part of routine procedure, most medical events occurring during a camper's visit will be treated and properly documented without notification of the parent or guardian. However, certain situations require that, in addition to the event being documented, the parent or guardian be notified in a timely fashion and in the method deemed most appropriate by the treating member of the health staff.

Examples of such situations include:

- | | |
|---|---|
| - moderate or several allergic reactions | -loss of consciousness |
| - serious injury from accident or altercation | -unresponsiveness |
| - severe sprains or strains | -any suicidal ideation |
| - snake bite | -violence against self or others |
| - asthmatic attack requiring outside medical intervention | -near drowning |
| - profound heat stroke | -exacerbation of any pre-existing medical condition |
| - seizure | - fractures |
| - any medical situation requiring off-site treatment | -paramedic intervention |
- NON-COMPLIANCE WITH MEDICATIONS PRESCRIBED
 - situations (not already enumerated) for which the parent/guardian has asked, via written request, to be notified
 - any other situation in which the health staff feels that parental notification is appropriate.

IMPORTANT MEDICATION INFORMATION FOR PARENT & PHYSICIAN

- All prescription medications brought to camp must have a medication order completed by a doctor. An incomplete medication order means we **cannot** give the medication.
- The medication must be in the original container with the campers name and only contain the amount to be used at camp.
- Please do not bring basic OTC medications unless it's Claritin. We have OTC's for most every ailment. We have a physician that has provided standing orders for common ailments.
- If a child uses a nebulizer please send them with their machine, along with the medicine and administration device.

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Camper Name: _____ Birth date: _____ Age: _____

Check if you wish the following **Over The Counter (OTC) medications** to be administered to your child during camp:
 Acetaminophen Ibuprofen, Benadryl Claritin, Antacids, Neosporin Ointment

The following will be administered on an as needed basis unless the parent/guardian indicates so by crossing them off:
Eye wash, cough drops (menthol), Vaseline lip balm, Sting relief (2% Lidocaine).

OTHER INFORMATION: If your child has a chronic condition such as asthma or diabetes, or is on prescribed medication, this must be filled out and signed by a physician. Please attach another page if more space is needed.

I (Physicians Name:) _____ Date: _____

have examined(applicant): _____ Height _____ Weight _____ Bld Pressure _____

Applicant is under my care for the following condition(s): _____

Treatment to be continued at camp: _____

Additional health information/major allergies: _____

Medically prescribed meal plan or dietary restrictions: _____

Any reported loss of consciousness/seizures/concussions? Yes ___ No ___ If yes, please explain: _____

This applicant may participate in all camp activities Yes ___ No ___ If no, please explain _____

FOR PRESCRIPTION MEDICATION, physician to fill out the following, include Epipens/Asthma Inhalers

Epipens/Inhalers to be given to the camper to carry.

Medication # ___ Name: _____ For _____

Amt to be given: _____ Route: _____ Frequency: _____

Medication # ____ Name: _____ For _____

Amt to be given: _____ Route: _____ Frequency: _____

Medication # ____ Name: _____ For _____

Amt to be given: _____ Route: _____ Frequency: _____

Physician's Signature: _____ **Phone:** _____

Address: _____ City: _____ Zip: _____

CONSENT- SIGNATURE REQUIRED FOR ATTENDANCE

The information listed on these forms is correct, to the best of my knowledge. My child is physically, mentally, and emotionally fit and I hereby give permission for her to participate in all authorized activities, except any restrictions listed above. I am aware that these activities may be physically challenging and because of the setting, certain natural risks and hazards may exist. I agree to indemnify and hold harmless Southern Hills, Inc. and its employees, servants and agents from and against all claims, loss, injury, death, or liability resulting from, arising out of, or in any way connected with camp activities.

I give permission to the camp nurse and/or trained personnel to administer prescribed, emergency, and OTC medications per doctor standing orders, to administer first aid, and to contact the camper's physician for consultation as needed. I understand that should my child have any ailments at Southern Hills, Inc camp that the health staff will treat my child per the Southern Hills, Inc. physician standing orders. I hereby give permission to Southern Hills, Inc. to arrange emergency medical transport (911) and for any treatment necessary by licensed medical professionals. I understand that I must provide transportation or pay the expense of emergency medical transport in case of major illness or injury. Southern Hills, Inc. will not assume liability of maintaining a combative, suicidal, or clinically ill person on site. I give permission to the physician selected by Southern Hills, Inc. to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child as named above.

Parent/Guardian Signature: _____ **DATE:** _____