River of Life Bible Camp
PO Box 726
Howland, ME 04448
207-732-4492 (seasonal)
www.rolbc.org

1. CAMPER REGISTRATION

Fill this form out completely and mail with your non-refundable deposit of $30.

Name(Last, First, Initial) ______________________________ Biological Gender at birth: ☐Male ☐Female

Address ______________________________ Age at camp time_______ Birthdate _____/____/______ (Month Day Year)

City/Town ______________________________ State_______ Zip _______________

Parent/Guardian ______________________________ Phone _________________ Cell ____________________

Parent/Guardian ______________________________ Phone _________________ Cell ____________________

Emergency Contact (if parent/guardian cannot be reached)

Name________________________________ Relationship ____________________________ Phone ______________________

Address ______________________________ City_________________ State______ Zip _________

---

2. CAMPER HEALTH INFORMATION

Insurance information *(Please complete the following):*

Carrier ________________________________ ID # ________________________ Group # ____________________

Health History (check all that apply):

Immunizations	Allergies	Chronic or Recurring Illness	Medication List
State of Maine Requires: That you provide River of Life Bible Camp with a copy of your child's Immunization records from your family Doctor. Thank You.	❒ Animals ❒ Food _____________ ____________________ ❒ Hay Fever ❒ Insect Stings ❒ Medicine/Drugs (specify) ____________________ ____________________ ❒ Pollen ❒ Other (specify) ____________________ Comments:____________ ____________________ ____________________	❒ Ear Infections ❒ Heart Defect/Disease ❒ Seizures ❒ Bleeding Disorders ❒ Nosebleeds ❒ Asthma ❒ Diabetes ❒ Musculoskeletal Disorders ❒ Bed Wetting ❒ Bowel Trouble ❒ Kidney Trouble ❒ Stomach Problems ❒ Bleeding Disorders ❒ Sleep Disturbances ❒ Fainting ❒ Other (specify) ____________________	*The following medications or their generic equivalent have been approved by the camp physician to be distributed by the camp nurse as needed. Please indicate which medications your child cannot have.* Tylenol/Acetaminophen Advil/Ibuprofen Robitussin DM Pepto Bismol Imodium Milk of Magnesia Docusate Sodium Benadryl/Antihistamine Claritin/Loratadine Anti-itch cream

Please describe conditions and give dates:

Operations or serious injuries: ____

Hospitalizations: ____

Other diseases/disabilities: ____

Special medical or dietary regimen to be followed? ____

____

Activity restrictions of which the camp staff should be aware? ____

____

3. MEDICATION

Is your child currently taking any prescription medications? ☐ Yes ☐ No

If *yes, please list medication(s), condition(s) being treated, dosage, and circle what time each is taken.*

MEDICATION

____	breakfast lunch supper bedtime other
____	breakfast lunch supper bedtime other
____	breakfast lunch supper bedtime other
____	breakfast lunch supper bedtime other

4. SELF-ADMINISTERED EMERGENCY MEDICATION *(ONLY FOR CHILDREN WITH INHALERS AND EPI-PENS)*

If your child needs to, and you want to permit your child to have readily available (carry or possess outside of the regular supervision of the camp's health staff) and to self-administer an inhaler, an epi-pen or other emergency medication, **you and your child's primary health care provider** must complete and sign the following consent. When your camper arrives at camp our health staff are required to evaluate the camper's self-administration technique to ensure proper and effective use.

As the **parent or guardian** of _________________________________, during his/her time at camp, he/she is permitted to have readily available (carry or possess outside of the regular supervision of the camp's health staff) and self-administer as medically necessary: (Check all that apply or list other emergency self-medication device.)

☐ Asthma Inhaler ☐ Epinephrine Pen ☐ Other _________________

As the **primary healthcare provider** for ___________________________________, during his/her time at camp, he/she is permitted to have readily available (carry or possess outside of the regular supervision of the camp's health staff) and self-administer the above medication as medically necessary.

____ ___________________

Primary Healthcare Provider Signature Date

5. PARENT/LEGAL GUARDIAN CONSENT

I hereby authorize River of Life Bible Camp and its camp nurse and/or approved staff to dispense over the counter medications needed including the medications listed above. I also authorize River of Life Bible Camp and its healthcare provider to dispense any prescription medication that my child takes as directed by my child's physician. I also will ensure that any prescription medication brought to the camp by my child will be in its **original bottle, will have enough for the duration of camp plus one day left in the bottle (unless special arrangements are made in advance),** will represent lawful use of the medication, and will not be expired or expiring during the time my child will be at camp.

By signing below, I as the Parent/Legal Guardian of _______________________________________, acknowledge that I have read and agree with the above information, and agree to comply with what is set forth herein.

Parent or Guardian Signature: ____ Date: __________________________

Parent or Guardian Name (printed): ____

Full Address (if different than child's): ____

---

6. PARENT/LEGAL GUARDIAN CONSENT FOR MEDIA USE

I give permission for River of Life Bible Camp to use video or photographs of my child in the camp brochure, video or website.

Name of Child: ____

Parent or Guardian Signature:____ Date: __________________________

Parent or Guardian Name (printed): ____ Phone Number: __________________

Full Address (if different than child's): ____

Please attach any additional information that will be helpful and relevant to care management for your child.