Florida's OverNight Summer Camp since 1999
CAMP FRONTIER
Location: 5000 Firetower Road, Haines City, FL 33844
Mailing: P.O. BOX 2555, Riverview, FL 33568
CampFrontier.com (888) 977-CAMP(2267)

INSTRUCTIONS FOR SUBMITTING THE

Emergency Contact, Medical History, Enrollment Agreement

One completed and notarized form is needed for each Camper attending.
This form must be sent to Camp Frontier at least **two weeks prior** to arrival day.

1) Download & Print from CampFrontier.com (One Form for each child please)

Home Page → Parent Links → Camper Handbook and Required Form

2) Complete the entire form (One Form for each child please)

3) Sign and have the form notarized (Form must be notarized).

4) Scan to a PDF file (Please scan each child's form to its own pdf file)
(No camera pictures please. Submitted form must be a PDF file.)
Along with all four pages of this form, include the front and back of the Child's insurance Card. You may include any related documentation you feel may be needed or helpful.

5) Rename the PDF File with the Camper's Name (as First Last – ie "Billy Smith")

6) Upload one PDF file per child via the link at CampFrontier.com
Home Page → Parent Links → Camper Handbook and Required Form

If you have any questions concerning the above please contact the Administrator, Dianne Collar, at Administrator@CampFrontier.com

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american CAMP association ACCREDITED

Emergency Contact, Medical History, Enrollment Agreement

(To be completed only by the Camper's parent or legal guardian. This form must be notarized)

Camper Information:

Last Name_____First Name_____Middle Name_____

Birth Gender: ☐ Boy ☐ Girl Date of Birth ___/___/___ (Month/Day/Year) Age upon arrival _____ Grade Entering _____

Social Security #_____ (Required for medical treatment for USA campers only)

Parent/ Guardian Information:

Parent/ Guardian Name(s)_____

Home Address_____City_____State____Zip_____

Child resides with (check all that apply): ☐Parents ☐Father ☐Mother ☐Step-Father ☐Step Mother

☐Other _____

Father: Home Telephone # (____)_____ Cell (____)_____ Email_____

Mother: Home Telephone # (____)_____ Cell (____)_____ Email_____

EMERGENCY CONTACTS (Please list three persons other than the above parents)

#1: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

#2: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

#3: Name_____Home Phone (____)_____Cell (____)_____Relationship_____

Any Comments concerning emergency contacts:_____

Camper's Doctor or Clinic: _____Telephone (_____)_____

Is the camper covered by Medical Insurance? ☐Yes ☐No

Insurance Company:_____ Insurance Company Phone #: (_____)_____

Name of Subscriber:_____ ID or Policy #_____

Coverage Effective Date:___/___/___ Additional Information: _____

Important: Please provide a copy of the insurance card, front and back.

Camper's Last Name _____ First Name _____Middle _____

Date of Birth _____/_____/_____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Please explain all "Yes" answers below.

Has/does the camper:

1. Ever required Hospitalization? ---------- ☐Yes ☐No
2. Ever had surgery? ---------- ☐Yes ☐No
3. Have frequent ear infections? ---------- ☐Yes ☐No
4. Had a recent infectious disease? ---------- ☐Yes ☐No
5. Have Heart Defect/ Disease? ---------- ☐Yes ☐No
6. Have Convulsions/ Seizures? ---------- ☐Yes ☐No
7. Have diabetes? ---------- ☐Yes ☐No
8. Have bleeding/ clotting issues? ---------- ☐Yes ☐No
9. Ever had high blood pressure? ---------- ☐Yes ☐No
10. Wear Glasses, contact, or protective eyewear? ---- ☐Yes ☐No
11. Ever had Psychiatric Treatment? ---------- ☐Yes ☐No
12. Have a disability? ---------- ☐Yes ☐No
13. Have a chronic or recurring illness? ---------- ☐Yes ☐No
14. Have allergies and allergic conditions? ---------- ☐Yes ☐No
15. Have any food or beverage allergies? ---------- ☐Yes ☐No
    Vegetarian, Lactose Intolerant, Gluten Intolerant, etc.
16. Have any food or beverage restrictions---------- ☐Yes ☐No
17. Have issues with bed wetting? ---------- ☐Yes ☐No
18. Ever had Strep Throat? ---------- ☐Yes ☐No
19. Ever had Lead Poisoning? ---------- ☐Yes ☐No
20. Ever had mononucleosis (mono)? ---------- ☐Yes ☐No
21. Ever had sickle cell? ---------- ☐Yes ☐No
22. Ever had a Head/ Neck Trauma/ Injury? ---------- ☐Yes ☐No
23. Ever broken a bone? ---------- ☐Yes ☐No
24. Ever had chicken pox? ---------- ☐Yes ☐No
25. Ever had measles? ---------- ☐Yes ☐No
26. Ever had mumps? ---------- ☐Yes ☐No
27. Ever had MRSA? ---------- ☐Yes ☐No
28. Have braces or retainers? ---------- ☐Yes ☐No

For Females: ☐Yes ☐No

29. Is the camper menstruating? ---------- ☐Yes ☐No
    Are cycles normal? ---------- ☐Yes ☐No
30. If no, is camper presently using prescription medication for regularity? ---------- ☐Yes ☐No

Please explain "Yes" answers in the space below, including the number of the questions. Please provide the approximate dates.

Medical History

For campers with special medical needs such as Epilepsy, Insulin-Dependent Diabetes, Cancer or any physically disabling condition requiring a wheel chair – please contact the Camp Office at 1-888-977-2267 prior to continuing with this form.

The following non-prescription medications are used by the camp Health Center to manage any illnesses. Please check the follow;

I give my permission:

Ibuprofen (Advil, Motrin) ---------- ☐Yes ☐No
Acetaminophen (Tylenol) ---------- ☐Yes ☐No
Pseudoephedrine decongestant (Sudafed) ---------- ☐Yes ☐No
Phenylephrine Decongestant (Sudafed PE) ---------- ☐Yes ☐No
Antihistamine/ Allergy Medication ---------- ☐Yes ☐No
Diphenhydramine Antihistamine (Benadryl) --------- ☐Yes ☐No
Guaifenesin Cough Syrup (Robitussin) ---------- ☐Yes ☐No
Bismuth subsalicylate for diarrhea (Imodium) ------ ☐Yes ☐No
Dextromethorphan Cough Syrup (Robitussin DM) ---------- ☐Yes ☐No
Sore Throat Spray ---------- ☐Yes ☐No
Cough Drops ---------- ☐Yes ☐No
Lice Shampoo or cream (Nix) ---------- ☐Yes ☐No
Laxatives (Natural, Vegetable) ---------- ☐Yes ☐No
Analgesic Cream ---------- ☐Yes ☐No
Antibiotic Cream ---------- ☐Yes ☐No

Please list any camp activities or programs in which the camper may <u>not</u> participate:

_____

_____

Camper's Last Name _____ First Name _____Middle _____

Date of Birth _____/_____/_____
Month/Day/Year

Immunization Records:

If your camper has not been fully immunized, please sign the following statement:

I request that _____be **exempt** from the immunization required for attendance at Camp Frontier.
Name of Camper

I understand and accept all of the risks for my child from not being fully immunized.

Signature of Parent/ Guardian: _____ **Date**: _____

Immunization History: Please provide the month and year for each of the immunizations listed. A copy of your camper's immunization form provided by your health care provider or local government, or a religious exemption form are also acceptable. If you choose to supply those documents, please attach copies to this form.

Immunization	Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month/ Year
Diphtheria, tetanus, pertussis *DTap or TdaP*					
Polio *IPV*					
Haemophilus influenza type B *HIB*					
Pneumococcal *PCV*					
Hepatitis B					
Mumps, measles, rubella *MMR*					
Varicella *Chicken Pox*					
☐Had Chicken Pox	Date:				
Tetanus Most Recent Dose	Date: Month/ Year				

In the past 12 months has the camper received treatment for ADD or ADHD? ☐Yes ☐No

In the past 12 months has the camper received treatment for an eating disorder? ☐Yes ☐No

Have a history of violent or destructive behavior? ☐Yes ☐No

Does the camper interact well with other children? ☐Yes ☐No

Does the camper interact well with adults? ☐Yes ☐No

Has the camper experienced a significant life changing event that continues to affect the camper's life? ☐Yes ☐ No
(Death of a family member or pet, history of abuse (physical or mental), adoption, foster care, change in Family (marriage, divorce), new sibling, survived a disaster, etc.)

If "Yes" please explain in the space below.

Any Additional Information – Please provide in the space below any additional information regarding the camper's health that is important.
If necessary, attach additional documentation.

Enrollment Agreement & Medical Release

All information provided is correct and complete to the best of my knowledge. I/We have read and understand the terms, policies and requirements of attending *Camp Frontier* and understand that signing this agreement confirms compliance. I/We release and hold blameless the employees, volunteers, and Board of Directors of Camp Frontier, Inc. from any and all claims of liability past, present and/or future. I/We acknowledge that Camp Frontier, Inc. fully owns and has complete discretion over the use of all photographs, Video and audio recordings created while the child is at camp.

Financial Policy
I/We understand that the total tuition must be paid as scheduled unless an alternative payment schedule has been established. I/We authorize the balance due (if any) to be charged to the provided credit card as described on the payment schedule. Should payments not be made as scheduled, any discounts and/or scholarships may be revoked and the full amount become due. A late fee of 1.5% late fee may be added monthly. I/We accept the financial responsibility for any and all damage to facilities or personal property for which our Child is found to be responsible.

Cancellation Policy
All registrations are final and cannot be cancelled unless Camp Frontier mutually agrees due to extreme circumstances. Cancellation is at the discretion of Camp Frontier. Please note that the full tuition is due even if a child does not attend the session(s) purchased.

Refund Policy
Any and all deposits, fees and/or tuition paid is non-refundable should the camper not attend, arrive and depart camp before the end of the session, or be expelled due to dishonest, disrespectful, inappropriate and/or violent behavior. Unused tuition dollars will be held on credit for the following summer for the registering family. If this child is not eligible to return these funds are transferred to the Scholarship Fund to be used by Scholarship recipients.

Medical Treatment
I/We give complete authorization for a representative of Camp Frontier, Inc. to request and receive any medical treatment in the event of need. I/We accept full responsibility for the payment of all medical services provided.

☐ Agree ☐ Refuse *(see below)*

If for religious of other reasons, you do not authorize Camp Frontier to provide medical treatment:
I/We release Camp Frontier, Inc. and Youth Adventures Foundation, Inc. of any liability or medical claims resulting from my decision to refuse medical treatment for the child. I/ We understand that in the event of a medical emergency I/We will be contacted by the Camp Office to establish care for the child. In the event that I/we cannot be reached, the child will be transported to the nearest Hospital/Medical Facility to receive treatment.

Signature: ×_____ Date: ___ /___ /___

Name (Printed) _____ Relationship to child: _____

Subscribed and sworn before me
this _____ day of _____, 20_____

(Stamp/Seal)

by _____

who is known to me.