



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BREAK-AWAY FOR A CHANGE

TEEN PROGRAMS Teen Spring Break-Away YMCA CAMP COLLINS

Over Spring Break YMCA Camp Collins offers a 3-day fun camp experience for teens in grades 8-12. This retreat is designed for both new and experienced campers. Experienced campers are invited to come back and enjoy the activities and fellowship they love at camp, while new campers can come get an idea of what teen camp programs are all about! It's the perfect way for teens to have a blast together in a beautiful outdoor environment over their Spring Break. The schedule is designed with structured activities as well as spaces for choice time to give teens supervised freedom to enjoy their favorite aspects of camp.

Activities May Include:

Rock Climbing	Challenge Course
Y Values Sessions	Teen Topic Workshops
Singing and Music	Hiking
Biking	Capture the Flag
Campfires	And much more...

To Register:

Complete the second page of this form and either mail or fax to YMCA Camp Collins. We hope you can join us for a fun-filled Spring Break-Away!



YMCA CAMP COLLINS
3001 SE Oxbow Parkway, Gresham, OR 97080
P 503 663 5813 F 503 663 2323 www.ymcacw.org

YMCA CAMP COLLINS – Registration Form

Teen Spring Break-Away – March 20-22, 2016

For Office Use Only

Please print carefully and return to: YMCA Camp Collins Registrar at:
3001 SE Oxbow Parkway, Gresham, OR 97080
P: 503 663 5813 F: 503 663 2323 E: campcollins@ymcacw.org

Camper's Name: First _____ Last _____ Gender: M F
 Address _____ City _____ State _____ Zip _____
 Home Phone# _____ Child's Birthdate _____ Current Grade _____
 Parent or Guardian Name _____ Relationship _____
 Address (if different) _____ City _____ State _____ Zip _____
 Work# _____ Cell# _____ Email _____

Camper Commitment: I want to become a camper at YMCA Camp Collins. I understand I may not possess or use tobacco products, alcoholic beverages, or non-prescription drugs while at camp. I will do my best to follow instructions, remain in designated areas, and keep others and myself safe. I will do my best to make this a good experience for my fellow campers and myself. I understand that failure to live up to this promise might result in my dismissal from camp without a refund.

Camper Signature _____ Date _____

Parent/Guardian Commitment and Cancellation Policy: I understand it is the camper's responsibility to participate in the whole camp program, including work, play, values sharing and living together. I understand and support the commitment that the camper has made above. I accept that failure to adhere to camp policies is cause for camper's dismissal from camp with no refund of fees. I am aware that camp activities involve a degree of risk and I approve of the opportunities the camper will have to participate in them. Included herewith is the required \$70 fee. Fees are due in full at time of registration and are non-refundable after March 1, 2016. I understand that no refunds are given if a child leaves camp early for any reason, drops within 3 weeks of start date or does not show up on the first day of camp.

Parent/Guardian Signature _____ Date _____

Photo Release: I authorize the YMCA to take, possess and use photographs, slides, and/or video of the applicant as may be needed for its public relations programs (This includes cabin group photographs.)

Parent or Guardian Initials _____

WAIVER/RELEASE: I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person or dependent children that might arise directly or indirectly as a result of, and or participation in YMCA Camp Collins program areas or activities. I hereby express release, discharge and hold harmless from any liability, losses, causes of action, expenses and/or claims for damages whatsoever the YMCA of Columbia-Willamette, the various branches and subdivisions thereof, and all employees and volunteers in their capacities as representatives of the YMCA, expressly including, but not limited to, the Board of Directors of the YMCA of Columbia-Willamette, except for injuries caused intentionally or by willful misconduct by such parties. I certify that I am familiar with the contents of this release, that I have read and understand the same, and it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors and assigns. I understand the risks involved in participation of outdoor recreational activities, and I am fully aware that there may be hazards and risks unknown to me, and I and/or my dependent children are physically able to participate in all the program areas offered at YMCA Camp Collins. I understand that I am responsible to pay my own medical and emergency expenses in the event of accident or illness regardless of whether I have authorized such expense. Furthermore, I am fully aware that the risks, known and unknown, can cause injury, property damage, illness, mental or emotional trauma, disability or death. This waiver and release will be construed broadly to provide a waiver and release to the maximum extent permissible under applicable law. Any provisions found to be void or unenforceable shall be modified or deleted to the minimum extent necessary to make them enforceable, and shall not effect the enforceability of any other provisions. I authorize the YMCA to have & use photographs, slides, and/or video tapes of the participant as may be needed for its public relations programs. I HAVE READ THIS AGREEMENT AND RELEASE, I UNDERSTAND IT AND I SIGN IT VOLUNTARILY.

Parent/Guardian Signature _____ Date _____

Fees and Payment Information:

This is a flat fee to include:
 Two-night stay at YMCA Camp Collins in our modern lodging facilities
 Seven meals
 Trained staff supervision
 Camp activities

Fees: \$70

Check enclosed with registration form.
 Charge the full fee of \$70 to my credit card now.
 Discover Visa Mastercard

Card # _____
 Name on Card _____
 Exp. Date _____ CVS 3-digit code _____
 Signature _____
 Today's Date _____



YMCA Camp Collins Health History Form - *Please submit with Registration*

Revised 9/2015

Child's full name _____ Age at camp _____ Birthdate _____ Gender: M F

Emergency Contact Information (If parent cannot be reached)

Emergency Contact Name 1: _____ Relationship: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Emergency Contact Name 2: _____ Relationship: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Insurance Information - Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Policy# _____

Name of policy holder _____ Relationship to participant _____

Phone number of carrier _____ Birthdate of policy holder _____

Health History - The following information must be filled out by the parent/guardian or adult staff member. We use this data to provide healthcare personnel with background information on the camper/staff and to educate counseling staff on camper needs.

Behavioral, Social, Developmental or other considerations: _____

Allergies: Please check all that apply to the participant.

This participant has no known allergies.

This participant has an allergy to the following foods: _____ Causes anaphylaxis? Yes No

Describe the reaction and what is done to manage it: _____

This participant is allergic to the following medications: _____ Causes anaphylaxis? Yes No

Describe the reaction and what is done to manage it: _____

This participant is allergic to the following substances: _____ Causes anaphylaxis? Yes No

Describe the reaction and what is done to manage it: _____

Diet: Please check all those that apply to participant. We can work with some medically prescribed diets but cannot cater to individual food preferences. Contact the [Camp Office](#) at 503.663.5813 if you have questions regarding the participant's diet while at camp.

Participant eats a regular, varied diet and is prepared to eat a wide range of foods.

Participant is gluten intolerant.

Participant is lactose intolerant.

Participant is a vegetarian.

Type: _____

Participant is a vegan.

Other, please describe: _____

Parent/Guardian Authorization for Health Care: This health history is correct, and the person described has permission to participate in all camp activities except as noted by me on the backside of this form and/or a physician. I attest that all immunizations required for school are up to date. I give permission to the medical personnel selected by YMCA Camp Collins to release any records necessary for insurance purposes and provide or arrange necessary related transportation for myself/my child in the case of a medical emergency. If I cannot be reached in an emergency, I give permission to the physician to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied. I understand that information about my child's health may be shared on a "need to know" basis with other camp staff.

Signature of custodial parent/guardian or adult staff

Date

I, _____ understand and agree to abide with any health related restrictions placed on my camp activities.

Camper Name

Signature of minor participant or adult staff

Date

Chronic Concerns

- This participant has no chronic health concerns and is capable of full participation in this program.
- This participant has the following chronic health concerns: (Check all that apply)

- | | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Surgical History | <input type="checkbox"/> Fainting | |
| <input type="checkbox"/> Other, please describe: _____ | | | |

Please provide information about supportive health care needed for each checked item above: _____

General Health Questions – Please explain “yes” answers in the space provided below.

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ever had a head injury within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Has high or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Ever have back problems?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Ever had problems with joints (ex. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Have an orthodontic appliance at camp?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Have any skin problems (ex. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>		
14. Have mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>		
16. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>		
17. Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
18. Any current physical, mental or psychological conditions requiring professional treatment or additional consideration?	<input type="checkbox"/>	<input type="checkbox"/>		

Explain “yes” answers and please note the question number.

Name of family physician _____ Phone _____
 Name of family dentist/orthodontist _____ Phone _____

<p>Which of the following Diseases has the participant had?</p> <p>_____ Measles _____ Mumps</p> <p>_____ Chicken pox _____ Hepatitis</p> <p>_____ German Measles</p> <p>_____ Date of last TB Mantoux test if taken. Result: _____</p>	<p>Immunization Verification</p> <p>My child received his/her last Tetanus shot (DTP or Booster) on _____ / _____ (This information is required in case of medical emergency)</p> <p style="text-align: center;"><small>*Month/ Year</small></p> <p><input type="checkbox"/> I verify that my child is up-to-date on ALL immunizations required for school.</p> <p><input type="checkbox"/> My child is Exempt from immunizations due to Medical, Religious, or other reasons.</p> <p>Parent Signature _____</p>
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Medications – You will be asked to complete a “Medications Being Taken” card on the first day of camp if your child is to take medications during their stay at camp. Medications (both prescription and over-the-counter) will only be accepted and dispensed by the Health Officer if provided in their **original container and with **current prescription** labeling. Please check medication labels and expiration dates prior to your arrival at camp. **The following medications, stocked in the Camp Health House, are used to manage illness or injury and dispensed as directed by our medical protocols. Please check the box next to those medications your camper SHOULD NOT be given:****

_____ Acetaminophen (Tylenol)	_____ Cough Medicine	_____ Night Time Cold Formula	_____ Tinactin (Anti-Fungal)
_____ Aloe	_____ Generic Cough Drops	_____ Pepto Bismol Tablets	_____ Triple Antibiotic Cream
_____ Allergy Medication	_____ Ibuprofen	_____ Pseudoephedrine (Sinus)	
_____ Benadryl	_____ Kaopectate (Anti-Diarrheal)	_____ Sore Throat Drops/Spray	ALL OKAY _____ (initial)

Are there any camp activities from which this participant should be exempt for health reasons? If so, please list.
 Is there any other information which has an impact upon the participant’s ability to fully participate in our program? If so, please list.

For Staff Use Only: Information Verification and Health Screening completed by:
 Staff Name (print please) _____ Date _____