For Office Use Only
_______ Received
_______ Chk #
_______ Amount Paid
_______ # on Check
_______ Meds

Royal Family KIDS® Camps
for Foster Children
7 - 11 Years Old
Sponsored by
TrinityLife

2122 West Joppa Road Lutherville, MD 21093
410-821-6573
July 22-27 • 2018

Return Completed Application to:
TrinityLife
Attn: Khristine Altizer
2122 West Joppa Road
Lutherville, MD 21093

Please enclose a photo of the camper.

REGISTRATION FORM

Instructions: *Please Print.* This form must be completely filled out. The information is vital to the health and well being of the child. Your application will be returned to you if it is not completely filled in.

Child's Last Name First Name Preferred Name Sex Birthdate

Street Age Current Emotional Age

City Zip School Grade Reading level

The child is living with: (Check one) ❑ Foster Parent ❑ Group Home ❑ Relative

Name(s) of person(s) the child is living with

_(_______)_______________________ (_______)_______________________
Home Phone: Work Phone

_______________________ (_______)_______________________
Emergency Contact Phone

Relationship to Child

_______________________ (_______)_______________________
Social Worker Day Phone Number

Moved in Foster Placement how many times? _________

Explain any unusual family circumstances that make camp especially important for the child:
(for example: recent crisis, being moved in foster placement, severe economic needs, etc.)

____

____

CAMPERS EMOTIONAL/BEHAVIORAL HISTORY

	Often	Sometimes	Not at all		Often	Sometimes	Not at all
Aggressiveness	❑	❑	❑	Night Terrors	❑	❑	❑
Bedwetting	❑	❑	❑	Nightmares	❑	❑	❑
Biting	❑	❑	❑	Runs Away	❑	❑	❑
Eating Disorders	❑	❑	❑	Sexual Acting Out	❑	❑	❑
Hyperactive	❑	❑	❑	Steals	❑	❑	❑
Learning & Disabilities	❑	❑	❑	Tantrums	❑	❑	❑
Lying	❑	❑	❑	Withdrawn	❑	❑	❑

Details from above:____

____

____

CAMPER DETAILS:

This child's swimming ability is: ❑ Good ❑ Poor ❑ Do not Know

Learning Disabilities: ❑ Yes ❑ No Reading Level:_______________________________

Has the child attended a Royal Family Kids Camp before? ❑ Yes, where?_____________________________ ❑ No

Camper T-Shirt Size: ❑ Child Small ❑ Child Medium ❑ Child Large ❑ Adult Small ❑ Adult Medium ❑ Adult Large

HEALTH HISTORY

Indicate all known allergies, illness, disabilities, physical limitations or medical complications:

Allergies ____

Illnesses/medical complications ____

Disabilities/Limitations____

❑ Leg or Arm Braces ❑ Hearing Aids Eating Disorder ❑ Yes ❑ No

Indicate date of illness, severity, complications, and any residual impairments.

Respiratory Problems	_____	Hypoglycemia	_____	Musculoskeletal Allergies	_____
Heart or Circulation	_____	Dizzy Spells	_____	Foot	_____
Pulmonary Edema	_____	Back	_____	Seizure Disorders	_____
Hay Fever	_____	Anaphylactic Shock	_____	Poison Oak	_____
Balance Problems	_____	Diabetes	_____	Fainting	_____
Insect Bites	_____	Drug Allergy	_____	Other	_____

Details from above:____

____

Any specific activities to be encouraged?____

Any specific activities to be restricted?____

IMMUNIZATION HISTORY:

Please fill in dates of basic immunizations and most recent booster as best as you can.

DTP Series _____ Booster	_____	Tetanus Booster	_____	Polio OPV (Sabin)	_____
Typhoid	_____	Measles Vaccine (live)	_____	Tuberculin (TB) Test	_____
German Measles (Rubella)	_____	Mumps Vaccine (live)	_____	Small Pox	_____

PRESCRIPTION MEDICATIONS: *All medication sent to camp must be in original container with the pharmacy label on it.*

Is your child taking any medications? ❑ No ❑ Yes, please fill in the following

1. Name_____________________________________Dosage:_____________________Times:________
2. Name_____________________________________Dosage:_____________________Times:________
3. Name_____________________________________Dosage:_____________________Times:________

What is(are) the medication(s) for:____

Doctor's Name_______________________________________Phone______________________________

Please add any other comments related to HEALTH and MEDICATIONS on an additional sheet.

I understand that it is my responsibility as caregiver to make sure that all instructions are clear and that the necessary dosage is adequately supplied for the duration of camp. I hereby authorize RFK's Camp nurse to administer the above medication from _________________ to _________________.
Day/Date Day/Date

_________________________________ _____________________________ ____________
Parent or Legal Guardian Signature Printed Name Date

MEDICAL RELEASE FORM:

This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of Royal Family KIDS Camp, or such substitute as they may designate, as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is enroute to and from or involved or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Director of Royal Family as legal guardian/social worker/other. I give my permission for ______________________________ (Camper) to attend Royal Family KIDS Camp in the summer of ________________ (Year) through **[church name]**.

______________________________________ Authorized Signature
______________________________ Printed Name
___________ Date

Child's Medicaid # ______________________

Signature: ____

Relationship to child: ____ Date ____________________________

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

I hereby give the Royal Family KIDS' Camp Registered Nurse permission to administer the following products according to manufacturer's instructions, or as otherwise specified.

I trust the RFK Camp Registered Nurse to use her best judgment as situations arise, and if in doubt, he/she can call for verification.

Please check YES or NO for the medications listed blow. This form must be completely filled out by the primary caregiver who signs below, or camper may not attend camp.

YES	NO		Specify if desired:
❑	❑	Sunblock	________________
❑	❑	Insect repellant	________________
❑	❑	Lip balm	________________
❑	❑	Rash ointment	________________
❑	❑	Tylenol	________________
❑	❑	Antiseptic ointment	________________
❑	❑	Band-aids	________________
❑	❑	Anti-itch cream	________________
❑	❑	Hydrogen peroxide	________________
❑	❑	Cough syrup	________________
❑	❑	Cough drops	________________
❑	❑	Decongestant	________________
❑	❑	Antihistamine	________________
❑	❑	Ipecac syrup	________________
❑	❑	Other	________________
❑	❑	Other	________________
❑	❑	Other	________________
❑	❑	Other	________________

Parent or Legal Guardian's Signature: ____

Printed Name: ____________________________ Phone numbers: ________________

Person Authorized to pick-up child ______________________________ ________________

PLEASE NO CAMERAS OR MONEY. THESE ITEMS ARE NOT NEEDED AT CAMP.