

## MULTIPLE CHILDRENS INFORMATION FORM 2018

1) **Child Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First M.Initial

**Sex**  Female  Male **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

2) **Child Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First M.Initial

**Sex**  Female  Male **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

3) **Child Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First M.Initial

**Sex**  Female  Male **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

4) **Child Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First M.Initial

**Sex**  Female  Male **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

5) **Child Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First M.Initial

**Sex**  Female  Male **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Home Address** \_\_\_\_\_  
Street City State Zip

*If not available in an emergency, please notify:*

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip

**HEALTH HISTORY**

**Child # 1 Name:** \_\_\_\_\_

Any known health issues we should be aware of? Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Allergies:** None Hay Fever Poison Ivy, Etc. Insect Stings Penicillin  
Other Medications Asthma Other: \_\_\_\_\_

**Current Medications:** (please send with instructions): None

**Dietary Modifications:** Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Disability, Behavioral Barriers, or Limitations we should know about** Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Name of child’s Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date of last Physical Exam:** \_\_\_\_\_

**Child # 2 Name:** \_\_\_\_\_

Any known health issues we should be aware of? Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Allergies:** None Hay Fever Poison Ivy, Etc. Insect Stings Penicillin  
Other Medications Asthma Other: \_\_\_\_\_

**Current Medications:** (please send with instructions): None

**Dietary Modifications:** Yes No

If YES please explain: \_\_\_\_\_  
**Disability, Behavioral Barriers, or Limitations we should know about** Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

Name of child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Physical Exam: \_\_\_\_\_

Child # 3 Name: \_\_\_\_\_

Any known health issues we should be aware of? Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

Allergies: None Hay Fever Poison Ivy, Etc. Insect Stings Penicillin  
Other Medications Asthma Other: \_\_\_\_\_

Current Medications: (please send with instructions): None

Dietary Modifications: Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

Disability, Behavioral Barriers, or Limitations we should know about Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

Name of child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Physical Exam: \_\_\_\_\_

Child # 4 Name: \_\_\_\_\_

Any known health issues we should be aware of? Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

Allergies: None Hay Fever Poison Ivy, Etc. Insect Stings Penicillin  
Other Medications Asthma Other: \_\_\_\_\_

Current Medications: (please send with instructions): None

Dietary Modifications: Yes No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Disability, Behavioral Barriers, or Limitations we should know about**  Yes  No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Name of child's Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date of last Physical Exam:** \_\_\_\_\_

**Child # 5 Name:** \_\_\_\_\_

Any known health issues we should be aware of?  Yes  No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Allergies:**  None  Hay Fever  Poison Ivy, Etc.  Insect Stings  Penicillin  
 Other Medications  Asthma  Other: \_\_\_\_\_

**Current Medications:** (please send with instructions):  None

**Dietary Modifications:**  Yes  No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Disability, Behavioral Barriers, or Limitations we should know about**  Yes  No

If YES please explain: \_\_\_\_\_  
\_\_\_\_\_

**Name of child's Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date of last Physical Exam:** \_\_\_\_\_

Suggestions or other information for program personnel:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*IMPORTANT\*\*\*This Box Must Be Complete For Attendance!!!\*\*\***

*This application and all information given are correct to my knowledge. The person herein described has permission to engage in all prescribed children activities except as noted.*

Emergency Authorizations: I hereby give permission to the medical personnel selected by the children's program personnel to order X-rays, routine tests, and treatment for me/or my child, EVEN if I can not be reached in an emergency. I hereby give my permission to the physician selected by the personnel to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

Tobacco, Alcohol, and Drug Policy: Children are prohibited from possessing or using tobacco and alcohol products and any illegal substances during the children's program. For the protection of all concerned, staff reserves the right to search campers and their personal belongings to enforce this policy. Campers who are found to have violated this rule are subject to expulsion from camp.

*I understand the policies as stated above and give my permission for my child to attend:*

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Photo/Video Release Agreement**

I, \_\_\_\_\_ hereby consent to the photographing of myself and the recording of my voice and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings for advertising, publicity, commercial or other business purposes. I understand that the term "photograph" as used herein encompasses both still photographs and motion picture footage.

I further consent to the reproduction and/or authorization by St. Luke's United Methodist Church to reproduce and use said photographs and recordings of my voice, for use in all domestic and foreign markets. I hereby release St. Luke's United Methodist Church, and any of its employees or associates from all claims of every kind on account of such use.

If participant is under 18 years of age, I, \_\_\_\_\_, am the parent/legal guardian of the individual named above. I have read this release and approve of its terms.

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_