



2024 Summer Camp Registration Packet: Camper

June

Regular Camps

Cultivate

6th-12th Graders
June 10th-14th
Early Bird: \$355
Regular: \$375

Energize

3rd-5th Graders
June 24th-28th
Early Bird: \$355
Regular: \$375

Mini Camps

Camp 234

2nd-4th Graders
June 17th-19th
Regular: \$200

Camp 567

5th-7th Graders
June 19th-21st
Regular: \$200

July

Camp-X

3rd-5th Graders
July 8th-12th
Early Bird: \$355
Regular: \$375

Missions

6th-12th Graders
July 15th-19th
Early Bird: \$355
Regular: \$375

Blast

3rd-5th Graders
July 22nd-26th
Early Bird: \$355
Regular: \$375

Registration: Register EARLY...many camps fill up QUICKLY! Prior to the start of camp, you will receive an email on what to bring, how to send messages, accessing camp pictures, and other vital information to make your camp experience the best. This will be sent to the email provided on your registration.

Scholarships: Scholarships for Summer Camp are available to those in need of financial assistance. To apply, please visit www.bluelakecamp.com/summer-camps/ to learn about our options .

Special Needs: We are very willing to provide for dietary needs such as allergies, special diets, programming needs or other support. Please indicate all relevant information on the camper's health forms, if you have additional questions please call us at 334-222-5407.

Early-Bird Rate: To obtain the early bird rate the camper must be registered and paid in full by April 1st.

Deposits: With a non-refundable \$50 deposit and a completed registration form, you may hold a spot until June 1, 2024. The total balance is due no later than June 1, 2024 at which time unpaid balances will be released. A spot cannot be held without a completed registration form. We cannot make ANY exceptions to this policy.

Cancellations & Refunds: Cancellations more than 2 weeks before your camp session begins will result in a refund less a \$50 administrative fee. Cancellations for any reason less than 2 weeks before your camp session is completely non-refundable.

2024 Summer Camp Registration

Participant Information: Camper

Please Circle which Camp
your Camper will be attending:

Cultivate	Energize	Camp-X	Missions
234 Mini Camp	567 Mini Camp		Blast

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Birth Date: _____ Grade: _____ Gender: _____

Church: _____

Parent/Guardian Name (if not applicable N/A): _____

Emergency Contact Name and Number: _____

Person(s) allowed to pick up your child (Required Information):

T-shirt size of the participant (available sizes are Youth Med - Adult XXXL): _____

Roommate Requests (limit 2 requests):

**Registration will not be finalized until FULL PAYMENT is received along with the
Registration, Health History and Agreement to Participate
forms - all completed and submitted.**

All forms may be found at www.bluelakecamp.com.

I understand and will comply with the Blue Lake Camp registration process and refund policy. I give my permission for Blue Lake Camp to use photos or videos of me and my child in promotional materials.

Signature of Parent or Guardian: _____ Date: _____

Camper's Name: _____ **Camp Attending:** _____

Payment Information:

Blue Lake Accepts Visa, Mastercard, EFT, and Checks (Payable to Blue Lake Camp)

Amount To Be Charged (\$50 deposit required to hold your spot): _____

Credit Card/EFT Info: Account Number (and routing number if using EFT): _____

Expiration Date: _____ 3 Digit Security Code on Back of Card: _____

Billing Address _____

Printed Name of Cardholder _____ Signature _____

Checks can be mailed to:

Blue Lake Camp

c/o Registrar

8500 Oakwood Lane,

Andalusia, AL 36420

Phone: 334-222-5407

Fax: 334-452-3012

Agreement to Participate; Assumption of Risk and Release of Liability

WHEREAS, THE UNDERSIGNED PARENT OR GUARDIAN wishes to have their child be accepted for participation in the Blue Lake United Methodist Assembly experience:

The undersigned acknowledge(s) that during the said Blue Lake United Methodist Assembly program for Summer Camp that their child or person(s), for whom they have responsibility, has requested to participate in, that certain risks and dangers may occur. These include, but are not limited to hazards of traveling wooded terrain, ropes course, using water borne craft such as a canoe, accident or illness in a remote place with medical facilities eighteen (18) miles away, and travel by various conveyance. The undersigned further recognizes that these risks may also include loss or damage to personal property, physical or psychological damage and/or injury not excluding fatality due to accidents which may occur, including accidents resulting from other types of outdoor activities. I further understand that in allowing my child or the person to whom I have responsibility to participate in camping activities he/she will be exposed to the elements of nature, including temperature extremes, and inclement weather. I further understand that medical treatment may be several minutes to an hour away in the event of a medical emergency.

I certify that my child or the person for whom I am responsible for, is healthy enough (both physically and emotionally) and capable of participating in this Blue Lake United Methodist Assembly program. I have listed on the Health Form any medical conditions that Blue Lake United Methodist Assembly, Inc., should be aware of which may hinder my child, or the person for whom I am responsible for, from participating in any particular activity. However, I understand that it is solely my parental or guardian responsibility to determine whether there is any medical reason that my child or the person for whom I am responsible for, should not participate in the Summer Camp Program at Blue Lake United Methodist Assembly, Inc.

In consideration of, and as part payment for the right to participate in such a camping program and the services and food arranged for my child or person for whom I am responsible for, by Blue Lake United Methodist Assembly, Inc., Directors, Officers, Employees, Agents, and/or Associates I have and do hereby assume all the above risk and any other ordinary risk incidental to the nature of the Blue Lake United Methodist Assembly program which is not specifically foreseeable, and will hold them harmless from any and all liability, actions, causes of action, debts, claims and demands of every kind and nature whatsoever, whether from bodily injury, property damage or loss or otherwise, which I now have or which may arise from or in connection with by camp or participation in any other activities arranged for me by Blue Lake United Methodist Assembly, Inc., its Directors, Officers, Employees, Agents and/or Associates, and their heirs, executors and administrators, successors and assigns and for all members of my family, including any minors accompanying me. In short, I cannot sue Blue Lake United Methodist Assembly, Inc., and if I do, I cannot collect any money. In addition, I will be liable for Attorney and Court fees associated with any litigation against Blue Lake United Methodist Assembly, Inc. I also state that my child or the person for whom I am responsible for, nor I, am not under, and will not be under the influence of any chemical substance including alcohol. I fully understand that my child's, and/or the child for whom I have responsibility for, physical activity involves risk of injury. I also understand that my child's or person for whom I have responsibility for, participation in Blue Lake United Methodist Assembly, Inc., program is entirely VOLUNTARY. I enter my child, or the person for whom I have responsibility for, enter into this Blue Lake United Methodist Assembly, Inc., program and take full responsibility for my decision for him/her to participate or not to participate and agree to follow all safety instructions.

Camper's Name: _____

Guardian's Name: _____

Guardian's Signature: _____ Date: _____

Camper Health History Form Phone: (334) 222-5407 Fax: (334)-452-3012	Dates will attend camp: From _____ To _____ Name: _____ First Middle Last Male: _____ Female: _____
Blue Lake Registrar 8500 Oakwood Lane Andalusia, AL 36420	Participant Information: Camp Attending _____

Home Address:

Street Address	City	State	Zip
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Minor Campers: Parent/Guardian that will be contacted in case of illness or injury:

Name: _____ Relationship: _____

Preferred Phone: _____ Preferred Email : _____

Home Address (if different from above):

Street Address	City	State	Zip
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Secondary Person if the first cannot be reached

Name: _____ Relationship: _____

Preferred Phone: _____ Preferred Email : _____

Home Address (if different from above):

Street Address	City	State	Zip
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Emergency contact if the first 2 are unavailable

Name: _____ Relationship: _____

Preferred Phone: _____ Preferred Email : _____

Allergies:

No Known Allergies: _____

This attendee is allergic to: Food _____ Medicine _____ The environment (Insect stings, hay fever, etc) _____ Other _____

Please describe below what the attendee is allergic to and the reaction seen.

Diet/Nutrition: This attendee eats a regular diet _____ This attendee eats a regular vegetarian diet _____

This attendee has special food needs. (Please describe below) _____

Restrictions:

_____ I have reviewed the program and activities of the camp and feel this person can participate without restrictions.

_____ I have reviewed the program and activities of the camp and feel this person can participate with the following restrictions.

(Please list the restrictions here) _____

Medical Insurance Information:

This person is covered by family medical/hospital insurance: ___ Yes ___ No

***Include copy of both sides of insurance card so information is readable.

Insurance Company: _____ Policy Number _____

Subscriber: _____ Insurance Company Phone Number: (____) _____

Parent/Guardian Authorization for Health Care for all MINOR CAMPERS:

This health history form is correct and accurately reflects the health status of the camp attendee to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand that if my child becomes ill with a contagious illness such as stomach virus, chicken pox, or flu they will be quarantined and parents will be required to come and pick their child up from camp. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____

Date: _____

Immunizations

- This person is current with all immunizations: Yes _____ No _____
- This person is not fully immunized: _____
- Please provide the date of the most recent Tetanus immunization: Month _____ Year _____

IF it has been 10 years or more since your child received a tetanus vaccination, we strongly recommend them receiving this vaccine PRIOR to attending camp.

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

I understand and accept the risks to me/my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship: _____

Medication: This person will NOT take any daily medications while attending camp: _____

This person WILL take the following daily medication(s) while at camp: _____

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please bring original pharmacy containers with labels for prescription medication** showing the prescribed name and how the medication should be given. All over the counter medication must be labeled with name and instructions for use. Provide enough of each medication to last the entire time at camp (and only the time at camp).

Name of medication	Date started	Reason for taking it	Breakfast Lunch Dinner Bedtime Other Time: _____	Amount or dose given	How it is given
			Breakfast Lunch Dinner Bedtime Other Time: _____		
			Breakfast Lunch Dinner Bedtime Other Time: _____		
			Breakfast Lunch Dinner Bedtime Other Time: _____		

Blue Lake does keep a stock of non-prescription medications in the camp Health Center and are used on an as needed basis to manage illness and injury.

Please list all Non-Prescriptions (if any) that the camper CANNOT take.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics
Council on School Health, & Association of Camp Nurses

Name:

First _____ Middle _____ Last _____

Birth Date: Month _____ Day _____ Year _____

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this person:

- | | |
|---|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? Yes No | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes No | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes No | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has this person:

- | |
|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No <input type="checkbox"/> |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Had a significant life event that continues to affect this persons life?..... Yes <input type="checkbox"/> No <input type="checkbox"/> |
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

If an emergency or illness arises such as stomach viruses, possible sprains, breaks, or need of doctor or hospital care you will be called before we seek medical help. We will not call for basic needs such as mild headaches, basic bumps and bruises, or scrapes and scratches.

What Have We Forgotten to Ask? Please provide in the space below any additional information about this persons health that you think important or that may affect this person's ability to fully participate in the camp program. Attach additional information if needed.