

Student Name: \_\_\_\_\_  
Guardian Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_

# Camp STARR Registration Forms

June 12-June 15, 2012

# 2012

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All the forms in this packet need to be filled out to ensure your student will attend Camp STARR 2012. Contact AmariYah Israel or Cierra Edwards at 216.752.3000 or [programs@diversitycenterneo.org](mailto:programs@diversitycenterneo.org) for questions or concerns.

## **CHECKLIST**

- Agreement to Participate**
- Student Publicity Release**
- Diversity Center Medical Release**
- Camp Campbell Gard Medical Release**
- Camp Joy Medical Release**

## **AGREEMENT TO PARTICIPATE IN CAMP STARR**

I understand that my child will act as a participant for Camp STARR retreat scheduled for June 12-15, 2012 sponsored by The Diversity Center of Northeast Ohio, Inc. In consideration for my child being permitted to participate in activities with The Diversity Center at Camp Joy and the National Underground Railroad Freedom Center, I (we), parent(s) and/or legal guardian(s) of:

\_\_\_\_\_ (Student Name), agree to the following provisions.

### **Acknowledgement**

I understand that there are numerous risks and benefits associated with participating in camping activities, including low initiatives/action challenge activities. I recognize that accidents occur and that all risks cannot be eliminated or controlled. Some, but not all, of the specific risks include:

Weather conditions which may change rapidly, causing injury directly (sunburn, hot/cold temperature extremes) or by affecting other factors (performance of equipment may be impaired). Some activities take place in a natural environment, where unexpected and unmarked objects and conditions create the risk of injury or death from falling, tripping, etc., insect or animal contact, and potentially harmful vegetations. Activities near water involve the risk of injury, illness, and drowning.

These are some but not all of the risks inherent in camping activities. There are also some risks which cannot be anticipated. Counselors, The Diversity Center staff, and the site staff will use their best judgment in determining how to react to circumstances including the aforementioned and other unpredictable, natural phenomena.

I acknowledge that I am aware of the possible risks, dangers and hazards associated with travel to and from location(s) to be visited during the retreat including transportation provided by commercial, private and/or public motor vehicles.

In the event that the child needs to be sent home, for any reason whether discipline or health related it will be the responsibility of the parent/ guardian to retrieve the child. The child shall be picked up within twelve hours.

### **Expectations of Participant**

Each participant is expected to:

- Respect & obey The Diversity Center staff and Counselors, as wells as all posted rules and regulations
- Assist by informing/alerting the group leader(s) to situations which may cause injury to themselves and others
- Abide under the "NO-TECH" rule while at Camp. NO Cell Phones or MP3 players allowed on Camp grounds. All devices will be confiscated for the duration of the camp and returned on departure back to Cleveland.

### **Specific Requirements**

Each participant should provide appropriate weather/survival clothing, including applicable footwear. The Diversity Center does not provide and assumes no responsibility for personal clothing, personal camping gear and the like, and/or injury arising from the participants' lack of use, or misuse of the same.

There are no physical, emotional, or mental problems or limitations associated with my child's participation in activities, except as disclosed by me in writing attached to the medical form.

The physical rigors involved require that each participant be of sound health considering the activities involved and that acceptable certification of participation be provided by parents/guardians.

### Release Provision

I, on behalf of myself and my child, hereby release and waive any claim of liability against The Diversity Center of Northeast Ohio, its agents, employees, officers, directors, successors and assigns with respect to any injury, illness, damage or death occurring to my child while he/she participates in any and all activities that are related to my child's participation. I understand that this release pertains to any negligence by The Diversity Center, its agents, employees, officers, directors, successors and assigns, as well as the negligence of any other participants to my child. I assume all risk of injury on behalf of my child.

I hereby agree to indemnify and hold harmless The Diversity Center of Northeast Ohio, its agents, employees, officers, directors, successors and assigns, with respect to any claim asserted by or on behalf of my child as a result of injury, illness, damage, or death.

### Consent and Signatory Acknowledgement

*Participant (including minors) – Acknowledgment of personal responsibility:*

**I have read and my parent/guardian has explained the terms of this agreement. I will abide by the terms of the Agreement and recognize my personal responsibility for my conduct.**

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parents or Guardians (of Minors):*

**I have read and fully understand the terms of this agreement, and explained its terms to my child. I give my permission for my child to participate in all camp activities, including those described.**

In my absence or inability to communicate with emergency and hospital personnel, I hereby grant authority to release, for the purpose of providing medical treatment, my child to the care of medical personnel or physicians as The Diversity Center of Northeast Ohio determine reasonably appropriate.

Parent/Guardian/ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: Custodial parents or guardians must sign this form.**

### PARENT/GUARDIAN/CAREGIVER CONTACT:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Daytime

Evening

Cell

### DESIGNATED ALTERNATE CONTACT (in case caregiver cannot be reached):

Name/Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Daytime

Evening

Cell



## STUDENT PUBLICITY RELEASE

Photographs, slides, and videotapes may be made during the duration of the retreat and participants are likely to be included in any of these. These photos, slides, and videos may be used in press releases, news stories, various Diversity Center of Northeast Ohio publicity pieces, or in similar publications. We hereby request permission to use any photographs, slides, or videotapes in which you appear for these purposes. Thank you for your consideration.

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I give my consent to use photographs, slides, or videotapes in which I/my child appear(s) for publicity purposes.

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PARENT/GUARDIAN SIGNATURE

DATE

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STUDENT SIGNATURE

DATE

## STUDENT AGREEMENT

I accept the challenge of being a participant at The Diversity Center of Northeast Ohio's Camp STARR retreat. As a participant, I acknowledge my responsibility to, myself and other participants.

I agree to be present at the retreat from Tuesday, June 12, 2012, through Friday, June 15, 2012. Unless I have arranged an alternate schedule with The Diversity Center of Northeast Ohio.

I will respect the rights and responsibilities of my participation and will join in the spirit of the retreat to the best of my ability.

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STUDENT SIGNATURE

DATE

**THE DIVERSITY CENTER OF NORTHEAST OHIO  
STUDENT MEDICAL INFORMATION & EMERGENCY RELEASE FORM**

Please print clearly. It is crucial that you complete all requested information.

\_\_\_\_\_  
High School

\_\_\_\_\_  
Student Participant Name

Age \_\_\_\_\_ Gender \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian: Name \_\_\_\_\_ Phone (home and cell) \_\_\_\_\_

\_\_\_\_\_  
Physician: Name \_\_\_\_\_ Phone (day & night) \_\_\_\_\_

\_\_\_\_\_  
Family Dentist: Name \_\_\_\_\_ Phone (day & night) \_\_\_\_\_

\_\_\_\_\_  
Medical Insurance - Provider & Number

**MEDICAL HISTORY:      Check all that apply.**

Diseases & Immunizations

\_\_\_ Chicken Pox

\_\_\_ Measles

\_\_\_ German Measles

\_\_\_ Measles, Mumps, Rubella Date \_\_\_

\_\_\_ Mumps

\_\_\_ Tetanus Booster Date \_\_\_\_\_

\_\_\_ Tuberculin Test Date \_\_\_\_\_

Ever had a reaction to any immunization? If so, please describe:

\_\_\_\_\_

**Allergies:**

\_\_\_ Hay Fever

\_\_\_ Asthma

\_\_\_ Poison Ivy, Sumac, Oak

\_\_\_ Insect Bites/Stings

\_\_\_ Food \_\_\_\_\_

\_\_\_ Medication \_\_\_\_\_

(type)

Currently taking medication for allergies? Please describe:

\_\_\_\_\_

**Chronic Illnesses:**

\_\_\_ Heart Disease

\_\_\_ Ear Infections

\_\_\_ Convulsions

\_\_\_ Diabetes

\_\_\_ Other

Please describe \_\_\_\_\_

**CURRENT HEALTH STATUS:**

Please describe any problems or conditions that could affect participation.

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Any special consideration, i.e. dietary needs, restricted activity, lodging preferences, etc? **PLEASE SPECIFY IF YOU ARE A VEGETARIAN, VEGAN, MAINTAIN A KOSHER DIET OR HAVE FOOD ALLERGIES!**

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Are you taking prescribed medication? If so, please list medication & dosage schedule.

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**GENERAL EMOTIONAL HEALTH:**

Camp STARR is an intellectually, physically, and emotionally challenging experience for young people. To assist the staff in providing a productive, supportive environment for all participants, please respond to the following questions. All information will remain strictly confidential.

Do you have particular emotional needs about which the staff should know? If yes, please explain briefly.

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Are you currently participating in psychological counseling? If yes, please give counselor's or physician's name, daytime and nighttime phone numbers (for emergency use only).

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**ADDITIONAL HEALTH INFORMATION:**

Please offer any necessary health information not included on this form:

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# JOY OUTDOOR EDUCATION CENTER

(dba Camp Joy)

## MEDICAL FORM & ACKNOWLEDGMENT OF RISK and RELEASE (printed on back)

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT.**

PARTICIPANT'S LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ **Circle One:** Chaperone / Participant

**Circle One:** Male / Female **Participant's Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone (\_\_\_\_):** \_\_\_\_\_

**Primary Contact:** \_\_\_\_\_ **Relationship:** (Parent / Guardian / Spouse / Other): \_\_\_\_\_

**Primary Contact #'s:** Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_

**IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY:** (List 2 contacts at 2 different addresses)

1. Name: _____ Relationship: _____	2. Name: _____ Relationship: _____
Address: _____	Address: _____
Home # (____) _____ Work # (____) _____	Home # (____) _____ Work # (____) _____
Cell # (____) _____	Cell # (____) _____

### PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

Policyholders First & Last Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICATIONS

Prescribed Medicine Name / Reason

1. \_\_\_\_\_ Immunizations: DPT Date \_\_\_\_\_ Tetanus Date \_\_\_\_\_

2. \_\_\_\_\_ Have you had Chicken Pox? Circle: Yes No

List any dietary restrictions: \_\_\_\_\_ List any activity restrictions: \_\_\_\_\_

List anything else, which would help us, better serve you: \_\_\_\_\_

### MEDICAL CONDITIONS

- Asthma (Does participant carry an inhaler?) \_\_\_\_\_
- Broken Bones
- Diabetes
- Ear Infections
- Headaches
- Heart Disease
- High Blood Pressure
- Infectious Hepatitis
- Psychiatric Care
- Pregnancy
- Fainting
- Convulsions/Seizures/Epilepsy Date of last Seizure: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### ALLERGIES: Check all that apply

- Hay Fever
  - Insect Stings
  - Poison Ivy, other plants: \_\_\_\_\_
  - Peanuts, other foods: \_\_\_\_\_
  - Penicillin, Other drugs: \_\_\_\_\_
  - Latex
- Describe Allergic Reaction: \_\_\_\_\_
- Does participant carry an Epi pen? \_\_\_\_\_
- (If yes please send Epi pen with participant and ensure s/he knows how to use it safely.)**

Please describe the management of the above conditions/allergies: \_\_\_\_\_

Describe and give dates of any hospitalizations, serious injuries or recurring illnesses: \_\_\_\_\_

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# Acknowledgment of Risk and Release

Revised 12/14/2011

**INSTRUCTIONS:** Please read this form carefully. EACH PARTICIPANT MUST SIGN THIS ACKNOWLEDGMENT OF RISK FORM BEFORE the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (dba Camp Joy) and Joy Outdoor Education Center Foundation, Inc., is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

*I am aware that experiential, outdoor pursuits such as living history reenactments (Ex. Underground Railroad), climbing, hiking, high ropes courses, ground initiatives, and other activities at Camp Joy, for which I have enrolled, entail certain risks.*

I understand that completing and signing the Center's Confidential Medical Form (attached) is a prerequisite for me or my child's participation in this program. I certify that the information my child or I have provided is complete and accurate.

Therefore, I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates, representatives, successors, and assigns, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether known or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any Camp Joy program, including, but not limited to any physical injury, psychological injury, loss of life or personal property that may occur as a result of participating in this program.

I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the program.

I understand that photography commonly occurs during Camp Joy programs. I consent for myself and/or my child/minor of legal responsibility to be photographed for general Camp Joy use, including program and/or agency printed/internet publicity.  Check this box to decline the photo release.

The health history is correct as far as I know, and the named participant has permission to engage in all prescribed program activities, except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant, and for the visiting organization or Camp Joy to secure and administer treatment, including hospitalization, for the participant named below.

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of participant (REQUIRED) Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
If participant is under 18, Date  
(Signature of Parent or Guardian is REQUIRED)

(Print Name Please)

NOTE: This participant shall NOT BE PERMITTED to participate in the following activities:

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

