

## **General Youth Conference and Cragmont Assembly Photograph & Video Release Form**

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse promotional settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations
- informational / promotional presentations

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational and promotional purposes.

Camper's Full Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Street Address/P.O. Box \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email Address \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

General Youth Conference – Cragmont Assembly  
Health Information Form  
July 22-27, 2024

Camper Full Name: \_\_\_\_\_

Gender:  Male  Female Birth Date: \_\_\_\_\_ Age upon arrival: \_\_\_\_\_ Weight: \_\_\_\_\_

Camper Home Address: \_\_\_\_\_

Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

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

(If different from above) – Street Address City State Zip Code

Second parent/guardian or other emergency contact

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Allergies:  No known allergies  This camper is allergic to:  Food  Medicine  Environment (insects, pollen, etc.)

Other

**Please list what the camper is allergic to and the reaction seen.**

Immunizations: Last tetanus shot: \_\_\_\_\_ (MUST be within the last 10 years)

**General Health History:** Check “yes” or “no” for each statement. Explain “yes” responses below, noting the question #.

- |  |   |
|--|---|
| 1. Have a recurrent/chronic illness(es)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 9. Have problems falling asleep/sleep walking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |
| 2. Had a recent infectious disease (last 6 months)? . <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have attention deficit/hyperactivity disorder? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 3. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 11. Being treated for emotional or behavioral difficulties or eating disorder? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had asthma/wheezing/shortness of breath? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No     | 12. Had a significant life event that continues to affect the camper’s life? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 5. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                               |   |
| 6. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                |   |
| 7. Wear glasses, contacts, of protective eyewear? . <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 8. Have any skin problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      |   |

Activity Restrictions:

- I have reviewed the example camp activities and feel the camper can participate without restrictions.  
 I have reviewed the example camp activities and feel the camper can participate with the following restrictions. (Please describe below)

Medication(s):  This camper will not take any daily medications while attending camp.  
 This camper will take the following medications while at camp: (Medications include prescription, over the counter products, vitamins, and supplements).

**Please list all medications and doses the camper will be taking while at camp. The camp nurse will contact you individually for further information closer to date.**

The following non-prescription medications may be stocked by the camp nurse and are used on an as needed basis to manage illness and injury. **Cross out any medications the camper should not be given.**

- |   |  |
|---|--|
| Acetaminophen (Tylenol)                                   | Phenylephrine decongestant (Sudafed PE)      |
| Ibuprofen (Motrin, Advil)                                 | Pseudoephedrine decongestant (Sudafed)       |
| Antibiotic cream  | Guaifenesin cough syrup (Robitussin)         |
| Aloe  | Dextromethorphan cough syrup (Robitussin DM) |
| Calamine lotion   | Sore throat spray                            |
| Antihistamine/allergy medicine (ex. Cetirizine [Zyrtec])  | Cough drops                                  |
| Diphenhydramine (Benadryl) antihistamine/allergy medicine | Calcium carbonate antacid (Tums)             |

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Diet/Nutrition:  The camper eats a regular diet.  The camper has specific dietary needs/intolerances.

**Please explain below.**

**Medical Insurance Information:** Identify any healthcare coverage/insurance the camper has:  Insurance  Medicaid  
 Self-Pay

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber's Name and Date of Birth: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

**Required to attach copy of insurance card/Medicaid card if appropriate. Copy must be front and back and readable.**

**\*Failure to include this information may result in registration delay.**

**PARENT / LEGAL GUARDIAN AGREEMENT / CONSENT**

By my signature below, I agree to and understand the following:

This health history is correct and accurately reflects the health status of the camper (minor child) to whom it pertains. The person described has permission to participate in all camp activities except as noted by myself. I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I understand the information on this form will be shared on a "need to know" basis with camp staff and medical personnel as necessary. I give permission to photocopy this form for medical use only.

Cost for all treatment / medicine will be the responsibility of the parent / legal guardian. Campers are covered by camp insurance with secondary coverage from the time they board their unit of transportation until they re-turn to their terminal; however, this will only cover accidents. Secondary coverage pays after my insurance. I have provided this insurance information in the event my child should need treatment by a physician / hospital.

If a camper requires confinement for illness for twenty-four (24) hours or more, the parent / legal guardian will be notified to pick up the camper.

It is my responsibility not to send a sick child to camp. If my child has a fever and / or any contagious condition the Sunday before camp, I am instructed not to send him/her to camp. I will be asked to come to Cragmont Assembly to pick up my child if he/she is deemed sick with a contagious condition.

All possible care will be used to prevent any accident and assigned adults will be responsible to see that any camper who gets sick or injured receives proper attention. I will be notified of any serious illness or accident.

I release and forever discharge Cragmont Assembly and each and every one of its employees, directors, counselors, and affiliates from all causes of action related to accidental injury or sickness acquired during camp week. I release and forever discharge Cragmont Assembly and each and every one of its employees, directors, counselors, and affiliates from all causes of action, suits, claims, demands, or any other damages or costs associated with actions taken by the Released Parties relative to the health, sickness, and treatment of \_\_\_\_\_.

(camper's name)

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

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

Type or PRINT Name (s): \_\_\_\_\_