

Butman Methodist Camp

2012 Camper Registration Form

Mail to: **Camp Registrar** Phone: **325-846-4212**
158 County Road 674 Fax: **325-846-3231**
Merkel, TX 79536 Email: **camp@butmancamp.org**
Web site: **www.butmancamp.org**

For office use only

Check # _____ \$ _____ \$ _____
Amount of check this camper

Check From: _____

Check # _____ \$ _____ \$ _____
Amount of Check this camper

Check From: _____

Early Bird Registration Special: If your registration is postmarked **on or before April 1, 2012** then the camper fee for **Young Elementary Camp** is \$122.50 and **all other camps** are \$225.00

Early Registration: If your registration is postmarked **on or before May 15, 2012** then the camper fee for **Young Elementary Camp** is \$132.50 and **all other camps** are \$240.00

Late Registration Fee: All registrations **postmarked after May 15, 2012** will be charged standard price. The price for **Young Elementary** is \$147.50 and **all other camps** are \$255.00

*****Please see www.butmancamp.org for costs, dates, and Camp Directors for each camp*****

Registrations must be complete and signed by the parent/guardian. Many churches financially help their youth pay for camp. Please contact your home church about this possibility. Please have pastor or appropriate staff sign registration form.

The signed and completed Medical Form and registration fee must accompany the Registration Form, or form will be returned for completion.

*****Please Print Legibly*****

*****Please Print Legibly*****

*****Please Print Legibly*****

Camp Registering For: Young Elementary 3-4 (June 11-13) Mid High Advance 6-8 (June 11-15)
(Check all that apply) New Dawn II (June 18-22) GRACE Camp 4-6 (July 30-Aug 3) call about fees
(for mentally challenged adults) Senior High Advance 9-12 (July 9-13)
 Elementary Advance 4-5 (July 9-13)

Camper Name _____
First (goes by) Middle Initial Last

Home Address _____
Street or Box Number City State Zip

Home Ph# (____) _____ **Cell #** (____) _____ **Camper e-mail** _____

School Grade Entering This Fall _____ **Age at Camp** _____ **Birth Date** _____ **Gender** ___ (M) ___ (F)

Home Church _____ **Phone#** (____) _____

Church Address _____
Street or Box Number City State Zip

Pastor's Name _____ **Pastor's Signature** _____
(Please print)

Parent/Guardian/Mother _____ **Parent/Guardian/Father:** _____

Address _____ **Address** _____
(If different from Camper) (If different from Camper)

Home Ph# (____) _____ **Home Ph#** (____) _____

Work Ph# (____) _____ **Work Ph#** (____) _____

Cell Ph# (____) _____ **Cell Ph#** (____) _____

Parent/Guardian Email: _____

Emergency Contact: _____

Relationship to Camper: _____ **Phone #** _____

Who will pick up camper after camp _____ **Camper have incarcerated parent?** Yes No
○ ○

Roommate Preference (1 only please) _____
(Roommate preference not guaranteed. Roommate preference not available for campers registered onsite.)

Camp Activities at **Butman Methodist Camp** may include but are not limited to: swimming, hiking, sports, water slide, group games, Ropes Course and Climbing Wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental to the camp setting and will hold the NWTX Conference, Butman Methodist Camp and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Butman Methodist Camp & Retreat Center to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, or on the camp's web site.

Custodial Parent/Guardian's Signature _____

Please Note: All camp fees include a \$10.00 nonrefundable registration fee.

Camper Medical Form

Camper Name: _____ **Camp(s) Registering For:** _____

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Immunization History: Please record the date (month/year) of basic immunizations and most recent boosters.

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – <i>Haemophilus influenzae</i> type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Hep A- hepatitis A		
Influenza		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Food Allergies
		Other Allergies

Does your child have Asthma? Yes No

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions or special requests _____

Activities to be encouraged or limited _____

Current medications: PLEASE FILL OUT ATTACHED FORM.

COMMENTS: Please list any special circumstances that might affect how the camper relates to others at camp. Examples: special dietary needs, short attention span, family or personal circumstances, etc.

For Females: Has this person begun menstruation? ____ yes ____ no If not, has she been told about it? ____ yes ____ no

If so, is her menstrual history normal? ____ yes ____ no Special Consideration? _____

To the Best of My Knowledge _____

is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility. **I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

Custodial Parent/Guardian Signature _____ **Date** _____

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company _____

Policy# _____ Group# _____

Insurance Address & Phone # _____

Family Physician Name & Phone # _____

CAMP NEW DAWN II HEALTH EXAMINATION FORM

**RETURN TO: Butman Camp Registrar
158 CR 674
Merkel, TX 79536**

Please have parent/guardian and physician complete appropriate sections of this form **in full** before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Camper Name: _____ Date: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP
***This section must be filled out before form is considered complete.**

- Is camper on a special diet? ___ Yes ___ No Explain _____
- Is camper on any special medicine? ___ Yes ___ No Explain _____
- Is camper on any new medication? ___ Yes ___ No Explain _____
- Is medicine being sent by parent/guardian? ___ Yes ___ No Explain _____
- Restrictions on swimming, diving? ___ Yes ___ No Explain _____
- Restrictions on strenuous activity? ___ Yes ___ No Explain _____
- Is camper able to dress self? ___ Yes ___ No Explain _____
- Is camper able to sleep in an upper bunk? ___ Yes ___ No Explain _____
- Is camper able to talk? ___ Yes ___ No Explain _____
- Does camper walk well? ___ Yes ___ No Explain _____
- Is camper an early riser? ___ Yes ___ No Explain _____
- Does camper wet the bed? ___ Yes ___ No Explain _____
- Does camper smoke or chew tobacco? ___ Yes ___ No Explain _____
- Is camper able to read? ___ Yes ___ No Explain _____
- Does camper have incontinence problems? ___ Yes ___ No Explain _____
- Is camper a sleepwalker? ___ Yes ___ No Explain _____
- Does camper wear protective garments (i.e. Depends) ___ Yes ___ No Explain _____

Camper's T-Shirt Size S M L XL XXL
Other _____

	Totally Independent	Partially Independent	Dependent
Brush Teeth			
Bathing			
Dressing			
Eating			
Toilet Usage			

PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician. **In the event that I cannot be reached in an EMERGENCY**, I hereby give permission to the physician, selected by the camp director, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Parent/Guardian Signature: _____ **Date:** _____

MEDICAL EXAMINATION
To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. **You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below.** Examinations are necessary for determining fitness/ability to engage in all activities.

CODE: S – Satisfactory U - Unsatisfactory (Explain) O - Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes _____ Extremities _____

Glasses _____ Posture (spine) _____

Ears _____ Skin _____

Nose _____ Allergy - Please specify: _____

Throat _____

Teeth _____

Heart _____

Lungs _____ General Appraisal: _____

Abdomen _____

Hernia _____

* (For girls and women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

Comments: _____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician Signature: _____ Date: _____

Address: _____ Telephone: () _____

Camper's Name: _____ Date Examined: _____ Cabin # _____ Year: _____

