



# PONDEROSA CAMPER REGISTRATION FORM

To be completed and signed by ALL PARTICIPANTS

**NOTICE:** For any camp over 72 hours (three days), The Colorado Department of Social Services also requires a statement be attached to this form confirming a health screening or physical signed by a physician or nurse practitioner performed in the last twenty four (24) months prior to camp.

Date(s) of camp session \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ to \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

**Camper's Name:** \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Male Female

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

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

**If the camper has permission to be walking or riding away from the campsite please sign here:**

X \_\_\_\_\_ Relationship \_\_\_\_\_

**Father's/Guardian's Name:** \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Employment Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

**Mother's/Guardian's Name:** \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Employment Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ + \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Individual(s) authorized to take child from camp (if applicable):**

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Individual(s) NOT authorized to take child from camp:**

Name: \_\_\_\_\_

**Camp activities which you do not wish your child to participate in:** \_\_\_\_\_

## HEALTH HISTORY

**Check any of the following that apply:**

- This camper has no known allergies
- This camper is allergic to the following medication(s) \_\_\_\_\_  
Describe Reaction \_\_\_\_\_
- This camper is allergic to the following (other) \_\_\_\_\_  
Describe Reaction \_\_\_\_\_

**Check if your child has or had the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Measles                                      |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Seizures         | <input type="checkbox"/> Heart Trouble                                |
| <input type="checkbox"/> Sleepwalking            | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Health Concerns for altitudes over 7000 feet |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Other _____                                  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Chicken Pox      |   |

**MORE ON BACK**

**Immunization Records:** Attach certificate of immunization or complete the following with dates

Diphtheria-Tetanus-Pertussis (DPT) \_\_\_\_\_ Tetanus-Diphtheria (DT) \_\_\_\_\_ Polio \_\_\_\_\_  
Measles-Mumps-Rubella (MMR) \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Haemophilus Influenza B (HIB) \_\_\_\_\_  
Other \_\_\_\_\_

**Medications Currently Taking:** Please list all and give how long they have been taking the medication

**Medications Bringing to Camp:** Please list all - Medications must be kept in the original container that identifies the camper's name, pharmacy, prescribing physician, name of the medication, dosage, and frequency of use. Due to state regulations, all camper medications must be kept in the nurse's facility.

**Preferred Over-the-Counter Medications (i.e. Tylenol, Advil, sinus medications):** These items are stocked at the Ponderosa and used to manage common illness or injury. These medications are dispensed by qualified health personnel as directed by standing orders signed by Ponderosa's supervising physician. **DO NOT SEND THESE MEDICATIONS WITH YOUR CHILD. THEY WILL NOT BE ALLOWED TO KEEP THEM IN THEIR LODGING OR ON THEIR PERSON.**

**These Medications Must be turned in to the Camp Nurse upon arrival at camp!**

Describe any special diet which the camper must follow: \_\_\_\_\_  
Physician prescribing special diet: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Last Physical Examination: \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE (DHS 7.711.61, A 9)**

I hereby give my permission to Ponderosa to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child \_\_\_\_\_ should an emergency arise. It is understood that Ponderosa will make a conscientious effort to locate the emergency contacts listed on the registration form before any action will be taken. If it is not possible to locate emergency contacts listed, I/we will accept the expense of emergency medical or surgical treatment.

**Parent or Guardian Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**INSURANCE INFORMATION**

Please provide information concerning any insurance benefits for which your child is eligible.

Insurance Carrier: \_\_\_\_\_  
Policy #: \_\_\_\_\_

*Ponderosa provides a limited accident reimbursement program to registered guests participating in sponsored activities. Any applicable claims must be submitted to the Ponderosa office,  
15235 Furrow Road, Larkspur, CO 80118-5703  
(719) 481-2482.*