



Registration Form

A separate form must be filled out for each person attending camp.

When: August 7-9, 2009

Where: Tallulah Falls, Georgia at Camp Chattooga, adjacent to Athens Y Camp (80 miles north of Atlanta)

Who: Children ages 5 to 17.

Cost: \$10 per child.

Scholarships available.

Registration Deadline: June 1, 2009

Camper's Information

Last Name: _____ Home Phone: _____

First Name: _____ Date of Birth: _____

Middle Initial: _____ Gender: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian E-mail: _____

T-Shirt Size (circle one): **Youth:** Sm Md Lg **Adult:** Sm Md Lg XL 2X

Have you attended United Hospice Foundation, Inc. d/b/a Camp Cocoon in the past? (circle one) Yes No

If yes, number of years attended in the past? _____

Loved One's Information:

Name: _____ Date of Death: _____

Cause of Death: _____

Camper's age at time of death: _____

Relationship to Camper (circle one): Mother Father Brother Sister Grandfather

Grandmother Uncle Aunt Friend Other: _____

Parent/Guardian(s) Information:

Father's Name: _____ Mother's Name: _____

Home Phone: _____ Home Phone: _____

Business Phone: _____ Business Phone: _____

Mobile Phone: _____ **Mobile Phone:** _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Name of Parent/Guardian(s) with whom child lives: _____

Relationship to child: _____

EMERGENCY CONTACT – Person to contact in case of emergency if parents cannot be reached:

Name: _____ Day Phone: _____

Relationship to child: _____ Evening Phone: _____

Parents: Married Widowed Separated Divorced

How did you hear about Camp Cocoon? Brochure United Hospice staff Radio Newspaper article
Word of mouth School Funeral home Other: _____

Transportation

Choose one:

- I will drop off my child at Camp Cocoon in Tallulah Falls between 4:00pm and 6:00pm on Friday, August 7, 2009.
- My Child will take the bus from Norcross Corporate Campus in Norcross to Camp Cocoon on Friday, August 7, 2009.

Choose one:

- I will pick up my child at Camp Cocoon in Tallulah Falls at 1:00pm on Sunday, August 9, 2009.
- My child will take the bus from Camp Cocoon to Norcross Corporate Office (arriving around 2:30pm) on Sunday, August 9, 2009.

Signature

I have read and understand the contents of this application.

Signature of Parent/Guardian

Date

Registration Information

- 1) All campers must have adequate health/accident insurance. **Mail completed registration form, copy of front and back of medical insurance card, along with \$10 fee to: United Hospice Foundation, 1626 Jeurgens Court, Norcross, GA 30093. No camper will be allowed into camp without a completed registration/medical form.**
- 2) Upon receipt of your registration, a confirmation packet and parent information will be mailed to you. For more information log on to www.unitedhospicefoundation.org or call (678) 533-6462 or (800) 956-5354. **Please read this entire application packet in its entirety and sign on all pages indicated. No incomplete registration forms will be accepted.**



Camper Health Form – 2009

Required by all campers by July 17, 2009. United Hospice Foundation, Inc. d/b/a Camp Cocoon cannot complete this form for you. Please provide complete medical information so that the camp can be aware of your child's needs.

Name: _____ Date of Birth: _____
First Middle Last

Name of Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

ALLERGIES: List all known

Medication Allergies

Describe reaction and management of the reaction

_____	_____
_____	_____
_____	_____

Food Allergies

_____	_____
_____	_____

Other Allergies – include insect stings, hay fever, asthma, etc.

_____	_____
_____	_____
_____	_____

Dietary Restrictions (Circle one):

None

Yes, describe below

Vegetarian: Yes No

_____ Other (describe) _____



Camper Health Form – 2009

General Questions (Explain “yes” answers in the space provided to the side of each question.)

Has your child / Does your child:

- | | | |
|--|-----|-------|
| 1. Had any recent injury or infectious disease? | Y N | _____ |
| 2. Have a chronic or recurring illness/condition? | Y N | _____ |
| 3. Been hospitalized in the last 18 months? | Y N | _____ |
| 4. Had surgery in the last 18 months? | Y N | _____ |
| 5. Have frequent headaches? | Y N | _____ |
| 6. Ever had a head injury | Y N | _____ |
| 7. Ever been knocked unconscious? | Y N | _____ |
| 8. Wear glasses, contact or protective eye wear? | Y N | _____ |
| 9. Ever passed out during or after exercise? | Y N | _____ |
| 10. Ever been dizzy during or after exercise? | Y N | _____ |
| 11. Ever had seizures? | Y N | _____ |
| 12. Ever had chest pain during or after exercise? | Y N | _____ |
| 13. Ever had frequent ear infections? | Y N | _____ |
| 14. Have an orthodontic appliance? | Y N | _____ |
| 15. Have a history of bed wetting? | Y N | _____ |
| 16. Ever had high blood pressure? | Y N | _____ |
| 17. Ever been diagnosed with a heart murmur? | Y N | _____ |
| 18. Ever had back problems? | Y N | _____ |
| 19. Ever had problems with joints (knees, ankles)? | Y N | _____ |
| 20. Have any skin problems (itching, rash, acne)? | Y N | _____ |
| 21. Have diabetes? | Y N | _____ |
| 22. Have asthma? | Y N | _____ |
| 23. Had mononucleosis in the past? | Y N | _____ |
| 24. Have problems with diarrhea/constipation? | Y N | _____ |
| 25. Have problems sleepwalking? | Y N | _____ |
| 26. If female, begun menstrual cycle? | Y N | _____ |
| 27. Ever had an eating disorder? | Y N | _____ |
| 28. Have ADD/ADHD? | Y N | _____ |

Which of the following has your child had?

- ___ Measles
- ___ Chicken Pox
- ___ German Measles
- ___ Mumps
- ___ Hepatitis A
- ___ Hepatitis B
- ___ Hepatitis C

TB Mantoux Test:

Date: _____

Result: Positive Negative

Please give dates of immunizations

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP/DTPaP	_____	_____	_____	_____	_____	_____
DT/Td	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
Hep. B	_____	_____	_____	_____	_____	_____
Hib	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____	_____

PLEASE NOTE: If your child has been exposed to any communicable disease, particularly chicken pox, measles or mumps 1-3 weeks prior to camp, please contact us as soon as possible.



Camper Health Form – 2009

SPECIAL NEEDS

Does your child use any special equipment such as a walker, crutches, wheelchair or prosthesis?

Please list any physical restrictions or activity limitations (i.e. no swimming, no prolonged sun exposure, no competitive sports, sight or hearing loss, limb amputation, has difficulty walking distances, requires assistance to dress or eat).

Is there anything we should know about your child that will make his/her adjustment smoother?

Describe any bedtime or sleep habits. (i.e. sleeps with parent, toys, talks/walks in sleep, etc.):

Does your child have any serious fears? Please describe.

Please indicate any further information about your child's **medical and/or emotional** needs that you feel we should know (sees a psychiatrist or psychologist regularly, ADHD, traumatic events, etc).



Consent Form

The following consent agreement must be signed by a parent or legal guardian of the minor child in order for the child to attend United Hospice Foundation, Inc. d/b/a Camp Cocoon.

Your signature below indicates approval of the following:

1. In the event that my child, _____, participates at United Hospice Foundation, Inc. d/b/a Camp Cocoon during the 2009 session, I hereby attest that this health history is correct so far as I know and the child named above has permission to engage in all prescribed camp activities except as noted. The staff of the Athens "Y" Camps and the United Hospice Foundation exercise caution in the conduct of all camp activities; however, they do not assume responsibility for accidents, injury or illnesses suffered by its campers.

I further understand that serious accidents occasionally occur during Camp activities, and that participants in Camp activities occasionally sustain mortal or serious personal injuries and/or property damage as a consequence thereof. Knowing the risks of Camp activities, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who (through negligence or carelessness) might otherwise be liable to my child or to me (or to my heirs or assigns) for damages.

2. United Hospice Foundation, Inc. d/b/a Camp Cocoon accepts no responsibility for the loss, damage or theft of your child's property.
3. Should you as a parent or guardian, during the Camp session leave your place of residence, you will advise the Camp administration where you can be contacted in the event of an emergency.
4. If you have any health and accident insurance coverage, please list:

Name of insurance company: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy No: _____ Medicaid No: _____

5. Notwithstanding Paragraph 1, I recognize and understand that United Hospice Foundation, Inc. d/b/a Camp Cocoon is operated by United Hospice Foundation, Inc. a charitable organization. My child and I are receiving all of the benefits of United Hospice Foundation, Inc. d/b/a Camp Cocoon with minimal or no costs to us and recognize that United Hospice Foundation, Inc. d/b/a Camp Cocoon is immune from suit under Georgia's Charitable Immunity Doctrine.
6. In case of medical and/or surgical emergency, you authorize United Hospice Foundation, Inc. d/b/a Camp Cocoon's medical staff to render to your child or to arrange for your child to receive any X-rays, anesthetic, medical, dental, surgical diagnosis, treatment, and hospital care which is deemed advisable by and is to be rendered under, the supervision of any physician, dentist or surgeon licensed to practice in the State of Georgia. I also grant permission for a licensed nurse to administer over-the-counter medication, such as ibuprofen, acetaminophen, antihistamine, as needed.
7. I acknowledge that reporters, photographers, videographers and other members of the media may attend United Hospice Foundation, Inc. d/b/a Camp Cocoon in order to increase the awareness about United Hospice Foundation, Inc. d/b/a Camp Cocoon and its programs. I grant permission for my child to be interviewed, photographed, and filmed by any member of the media at United Hospice Foundation, Inc. d/b/a Camp Cocoon. I understand that United Hospice Foundation, Inc. d/b/a Camp Cocoon is not responsible for the content of the media coverage and that my child will not be paid for any media work.
8. United Hospice Foundation, Inc. d/b/a Camp Cocoon and its representatives have absolute permission to use my child's image in a photograph or video or my child's artwork that pertains to the lawful programs and activities of the Camp.
9. All information is correct so far as I know and the child being described has permission to engage in all prescribed Camp activities, except as noted by me and the examining physician.

Signature: _____ Date: _____

Print Name: _____ Relationship to Camper: _____

Camper's Name: _____