



CAMPER APPLICATION

THURSDAY-SUNDAY

July 28-31, 2022

Ages 16-18

CO-ED

Section 1. Please fill out the information completely.

Camper's Full Name			Name teen prefers to be called		
Sex (M/F)	Birthdate (M/D/Y)	Age	Adult Shirt Size (S-2XL)	Shoe Size	Dress/Pants Size
Name of Teen's Social Worker		Social Worker's Phone Number		Social Worker's Email	
Name of Teen's Case Manager		Case Manager's Phone Number		Case Manager's Email	
Name of Person Teen is Living With		Relationship to Teen (Bio-Parent, Adoptive Parent, Foster Parent, Group Home, etc.)			
Street Address		City		State	Zip Code
Home Phone		Cell Phone		Work Phone	
Email Address					
Emergency Contact			Phone		
Length of Time Teen Has Been in This Home			Has Teen Attended TGAC (Yes/No) If yes, which year(s)?		
Names of Other Foster Children Living in This Home					

Section 2. Please help us get to know this teen better so we can provide positive interactions and activities at camp. Check the boxes which best describe the teen most of the time.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Social | <input type="checkbox"/> High Energy | <input type="checkbox"/> Talkative | <input type="checkbox"/> Sense of Humor |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Serious | <input type="checkbox"/> Planner | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Orderly | <input type="checkbox"/> Competitive | <input type="checkbox"/> Determined | <input type="checkbox"/> Peacekeeper |
| <input type="checkbox"/> Not Interested in Sports | <input type="checkbox"/> Watches Before Doing | <input type="checkbox"/> Likes to Get Things Right | <input type="checkbox"/> Likes to Perform for Others |
| <input type="checkbox"/> Kind | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Negative | <input type="checkbox"/> Leader |

Section 3. Medical History

Primary Care Doctor's Name _____ Phone Number _____

Medical Insurance Company _____ Insurance ID # _____

Name of Counselor/Psychologist _____ Phone Number Ext. _____

Are the teen's immunizations up to date? (Yes/No) _____

Please list **ANY** medical conditions (mental or physical) treated by a doctor in the last year.

Does the teen have any physical disabilities, illnesses, or other limitations? (Yes/No) If yes, please describe.

Has the teen experienced any of the following? Please check and indicate date of illness, severity, complications, and any residual impairment.

- | | | |
|---|---|--|
| <input type="checkbox"/> Respiratory Problems _____ | <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Musculoskeletal Allergens _____ |
| <input type="checkbox"/> Heart or Circulation _____ | <input type="checkbox"/> Dizzy Spells _____ | <input type="checkbox"/> Foot _____ |
| <input type="checkbox"/> Pulmonary Edema _____ | <input type="checkbox"/> Back _____ | <input type="checkbox"/> Seizure Disorders _____ |
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Anaphylactic Shock _____ | <input type="checkbox"/> Poison Oak _____ |
| <input type="checkbox"/> Balance Problems _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Fainting _____ |
| <input type="checkbox"/> Insect Bites _____ | <input type="checkbox"/> Drug Allergy _____ | <input type="checkbox"/> Other _____ |

Details from above:

Please list **ALL** medications the teen is taking. If you need more room, please finish listing on the back of the application.

Name of Medicine	Prescribed For	Dosage/Amount	Time(s) Given

Section 4. Emotional and Behavioral History. Indicate with an “X” the degree to which the teen displays the following emotions/behaviors. Please answer honestly. Negative behaviors do not disqualify a teen from attending camp. You will have space to explain on the next page.

	Often	Sometimes	Never
Aggression/Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Eating Disorder/Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn/Sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For all behaviors marked in Section 4., please put known triggers that cause the behavior and how you handle it at home:

Section 5. Medical and Liability Release

MEDICAL RELEASE: This health history is correct so far as I know, and the above named minor has permission to engage in all prescribed program activities. The undersigned does hereby authorize the directors of CrossRoads/Flint Hills Foster Teen Camps or such substitute as they may designate as agent for the undersigned to consent to an X- ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician/surgeon licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, at camp or elsewhere. This authorization will remain effective while the above minor is en route to and from or involved in or participating in any camp program, unless revoked in writing by a medical professional(s) and delivered to the Camp Director. During camp, prescription medication will be administered to teen as directed by a physician. CrossRoads/Flint Hills Foster Teen Camps will do everything in its power to prevent incorrect medicine from being given. However, CrossRoads/Flint Hills Foster Teen Camps is not liable for incorrect medicine provided to us by the legal guardian, incorrect dosages given, nor is it liable for wrong labeling on medicine bottles. Legal guardians are responsible for checking in the correct medication, bottles and dosages at the time of registration. **This is not the time to give medication vacations to your teen.**

LIABILITY RELEASE: Every precaution will be taken to protect campers and volunteers from harm, but CrossRoads/Flint Hills Foster Teen Camps is not liable for injuries/death that teen or volunteer staff may incur while camping or participating in CrossRoads/Flint Hills Foster Teen Camps activities. All extension activities are included.

Parent or Legal Guardian's Signature

Date

Printed Name

Relationship to Teen

Send the following to:

CROSSROADS
c/o Lisa Irvin
4122 Living Water Road
Olsburg, KS 66520
Phone: 785-410-2995
Fax 785-468-3201
Email director@fhftc.org

- Completed Application
- Copy of Health Insurance/Medicaid Information
- Recent Photo of Teen

Section 6. Permission to Administer First Aid and Over-the-Counter Medications

I hereby give CrossRoads/Flint Hills Foster Teen Camps medical professional(s) permission to administer first aid and the following products according to manufacturer's instructions, or as otherwise specified.

I trust CrossRoads/Flint Hills Foster Teen Camps medical professional(s) to use his/her best judgement as situations arise, and if in doubt, he/she can call for verification.

Please check YES or NO for the medications listed below. This form must be completely filled out by the primary caregiver who signs below, or teen may not attend camp.

Yes	No	Medication	Specify, If Desired:
<input type="checkbox"/>	<input type="checkbox"/>	Sunscreen	
<input type="checkbox"/>	<input type="checkbox"/>	Insect Repellent	
<input type="checkbox"/>	<input type="checkbox"/>	Lip Balm	
<input type="checkbox"/>	<input type="checkbox"/>	Rash Ointment	
<input type="checkbox"/>	<input type="checkbox"/>	Tylenol	
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen	
<input type="checkbox"/>	<input type="checkbox"/>	Band-Aids	
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic Ointment	
<input type="checkbox"/>	<input type="checkbox"/>	Anti-Itch Cream	
<input type="checkbox"/>	<input type="checkbox"/>	Hydrogen Peroxide	
<input type="checkbox"/>	<input type="checkbox"/>	Cough Drops	
<input type="checkbox"/>	<input type="checkbox"/>	Decongestant	
<input type="checkbox"/>	<input type="checkbox"/>	Antihistamine	
<input type="checkbox"/>	<input type="checkbox"/>	Pepto-Bismol	
<input type="checkbox"/>	<input type="checkbox"/>	Tums	
<input type="checkbox"/>	<input type="checkbox"/>	Epi-Pen (In case of allergic reactions)	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

Parent or Legal Guardian's Signature

Date

Teen's Name

Relationship to Teen

Section 7. Consent Form

COACHES/STAFF:

Every effort will be made to contact the teen's coach from previous years at The Great Adventure Camp/CrossRoads so that consistency can be achieved from camp to camp. However, this is not always possible. All CrossRoads/Flint Hills Foster Teen Camps coaches and staff will be interviewed, background checked and trained before being on staff.

CONFIDENTIALITY:

Every teen registered at CrossRoads/Flint Hills Foster Teen Camps has the right to confidentiality. Our coaches are instructed not to take pictures of/with, exchange addresses, phone numbers, e-mail addresses, or social media information with any camper. Any videos or pictures that are obtained by CrossRoads/Flint Hills Foster Teen Camps will be edited by blocking out faces if used in any promotional medium.

SAFETY/LIABILITY:

Teens will be participating in a challenge course. Safety and every precaution will be taken to protect them from harm. CrossRoads/Flint Hills Foster Teen Camps staff is very aware of our responsibility to each teen's safety, but CrossRoads/Flint Hills Foster Teen Camps and Living Water Ranch, Inc. are not liable for injuries/death that teens or volunteer staff may incur while camping or participating in CrossRoads/Flint Hills Foster Teen Camps activities.

MEDICATION APPLICATION:

During camp (3 full days), medication will be administered to teens as directed by a physician. CrossRoads/Flint Hills Foster Teen Camps will do everything in its power to prevent incorrect medicine from being given. However, CrossRoads/Flint Hills Foster Teen Camps and Living Water Ranch, Inc. are not liable for incorrect medicine provided to us by the legal guardian, incorrect dosages given, nor is it liable for wrong labeling on medicine bottles. Legal guardians are responsible for checking in the correct medications, bottles and dosages at the time of registration. **This is not the time to give medication vacations to your teen.**

FINANCIAL COMMITMENT:

CrossRoads/Flint Hills Foster Teen Camps is a nonprofit organization. We operate by volunteer hours and funds committed to running this program. If you would like to make a charitable donation to CrossRoads please send it to:

CROSSROADS
c/o Lisa Irvin
4122 Living Water Road
Olsburg, KS 66520

You will receive a charitable contribution receipt to submit with your tax return.

I have read the above and understand that by signing my name as legal guardian of:

Teen's Name

that I agree that CrossRoads/Flint Hills Foster Teen Camps Staff and Coaches will take every precaution to protect said teen from harm. However, in any instance they are injured I have given medical information and permission to take them to a medical facility for proper care. I release CrossRoads/Flint Hills Foster Teen Camps and Living Water Ranch, Inc. from any liability surrounding said teen's injury/death.

Parent or Legal Guardian's Signature

Date