

Vacation Bible School  
Application/Release Form  
Gresham Corps Youth Center  
August 2-6 2010



DOING THE  
MOST GOOD<sup>SM</sup>

**Personal Information Delegate**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Behavior Agreement**

*I AGREE to follow the center rules and I understand that if I violate the center rules that I may be suspended.  
I understand that The Salvation Army is not responsible for lost or stolen items.*

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Your Parent/Guardian**

**Behavior Agreement**

I understand that if my child violates the Youth Center rules they may be suspended. Initial \_\_\_\_\_ (We will contact you to inform you of this decision and work together to develop an agreement for return to the Youth Center.)

I also understand The Salvation Army is not responsible for lost or stolen items. Initial \_\_\_\_\_

**Permission to Travel**

I understand that my child may participate in field trips by The Salvation Army Gresham Corps including religious services. I understand that my child will be traveling in The Salvation Army vehicles as a part of The Salvation Army outing. The health history is correct so far as I know, and the person herein described has permission to engage in all prescribed outing activities except as noted. Initial \_\_\_\_\_

**Authorizations for treatment:** I hereby give permission to the medical personnel to order X-rays, routine tests, treatment; to release any protected health information or records necessary for insurance purposes or outing operations; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the outing director to secure and administer treatment, including hospitalization for the child named above. Initial \_\_\_\_\_

**Publicity Release:** I hereby give permission for my child to be photographed or be in a video for the possibility of being used in Salvation Army publicity and I give exclusive right to these photos to The Salvation Army and waive all claims for compensation for such usage. Initial \_\_\_\_\_

**Parental Consent**

I hereby authorize my child to participate in **The Salvation Army Gresham Corps VBS** program.

As the parent or legal guardian of the above named minor, agree to relieve The Salvation Army or its directors, officers, employees, agents or other representative from any and all liability in connection with any loss, damage or injury arising in connection with my child's participation in this program.

Initial \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

# DELEGATE HEALTH AND MEDICAL HISTORY



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This page to be filled out by parent or legal guardian. Please read carefully.  
**All participants must be able to administer his/her own medications**

Delegate Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
LAST FIRST INITIAL

Parent / Legal Guardian / Spouse \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
STREET & NUMBER CITY STATE PROVINCE (AREA CODE) - NUMBER

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
STREET & NUMBER CITY STATE PROVINCE (AREA CODE) - NUMBER

Emergency Contact Name: (Please Print): \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
STREET & NUMBER CITY STATE PROVINCE (AREA CODE) - NUMBER

**HEALTH HISTORY**  
 (Check and give approximate dates.)

Frequent Ear Infections  
 Heart Defect/Disease  
 Convulsions/Seizures  
 Diabetes  
 Bleeding/Clotting Disorders  
 High Blood Pressure  
 Mononucleosis  
 Psychiatric Treatment  
 Strep Throat  
 Lead Poisoning  
 Sickle Cell

**Diseases**

Chicken Pox  
 Measles  
 German Measles  
 Mumps

**Allergies/Allergic Conditions**

Hay Fever  
 Poison Ivy, etc.  
 Insect Stings (reaction?) \_\_\_\_\_  
 \_\_\_\_\_  
 Penicillin  
 Other Drugs  
 Asthma (reaction?) \_\_\_\_\_  
 \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_  
 \_\_\_\_\_

Has delegate ever required hospitalization, medical, or other treatment? \_\_\_\_ Yes \_\_\_\_ No Explain: \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Disability or chronic or recurring illness \_\_\_\_\_

Other diseases/conditions \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Special restrictions or considerations regarding health related information while at camp: \_\_\_\_\_

\_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

**Name of family physician/clinic** \_\_\_\_\_

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

Do you carry family medical/hospital insurance \_\_\_\_ Yes \_\_\_\_ No

If so, indicate: Carrier \_\_\_\_\_

Policy or Group # \_\_\_\_\_

Medical Assistance # \_\_\_\_\_

**For Females** (under age 18)  
 Has this person menstruated? \_\_\_\_\_ If not has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special considerations? \_\_\_\_\_

**This box must be signed & dated prior to membership**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed outing activities except as noted.

**Authorization for treatment:** I hereby give permission for the outing personnel to give my child First Aid and medication as described in the retreat standing orders, to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself/my child. In the event I (parent or guardian) or my emergency contacts cannot be reached in an emergency, I hereby give permission to the physician selected by the outing director to secure and administer treatment, including hospitalization, for my child (camper under age 18) named above. The completed forms may be photocopied for transport.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 SIGNATURE OF PARENT / LEGAL GUARDIAN / ADULT CAMPER OVER AGE 18 DATE

I also understand and agree that the person documented above will abide with the restrictions placed on his/her camp activities.

The sole purpose of this information is to identify appropriate health care needs.