Student Name: ____

Guardian Name: ____

Emergency Contact: _______________________________________

Camp STARR Registration Forms

June 14-June 17, 2011

2011

All the forms in this packet need to be filled out to ensure your student will attend Camp STARR 2011. Please DO NOT un-staple packet. Contact Eris Dyson or Cierra Edwards at 216.752.3000 or programs@diversitycenterneo.org for questions or concerns.

CHECKLIST

__Agreement to Participate

__Student Publicity Release

__Diversity Center Medical Release

__Camp Joy Medical Release

AGREEMENT TO PARTICIPATE

I understand that my child will act as a participant for Camp STARR retreat scheduled for June 14-17, 2011 sponsored by The Diversity Center of Northeast Ohio, Inc. In consideration for my child being permitted to participate in activities with The Diversity Center at Camp Joy and the National Underground Railroad Freedom Center, I (we), parent(s) and/or legal guardian(s) of:

____(Student Name), agree to the following provisions.

Acknowledgement

I understand that there are numerous risks and benefits associated with participating in camping activities, including low initiatives/action challenge activities. I recognize that accidents occur and that all risks cannot be eliminated or controlled. Some, but not all, of the specific risks include:

Weather conditions which may change rapidly, causing injury directly (sunburn, hot/cold temperature extremes) or by affecting other factors (performance of equipment may be impaired). Some activities take place in a natural environment, where unexpected and unmarked objects and conditions create the risk of injury or death from falling, tripping, etc., insect or animal contact, and potentially harmful vegetations. Activities near water involve the risk of injury, illness, and drowning.

These are some but not all of the risks inherent in camping activities. There are also some risks which cannot be anticipated. Counselors, The Diversity Center staff, and the site staff will use their best judgment in determining how to react to circumstances including the aforementioned and other unpredictable, natural phenomena.

I acknowledge that I am aware of the possible risks, dangers and hazards associated with travel to and from location(s) to be visited during the retreat including transportation provided by commercial, private and/or public motor vehicles.

In the event that the child needs to be sent home, for any reason whether discipline or health related it will be the responsibility of the parent/ guardian to retrieve the child. The child shall be picked up within twelve hours.

Expectations of Participant

Each participant is expected to:

- Respect & obey The Diversity Center staff and Counselors, as wells as all posted rules and regulations
- Assist by informing/alerting the group leader(s) to situations which may cause injury to themselves and others
- Abide under the "NO-TECH" rule while at Camp. NO Cell Phones or MP3 players allowed on Camp grounds. All devices will be confiscated for the duration of the camp and returned on departure back to Cleveland.

Specific Requirements

Each participant should provide appropriate weather/survival clothing, including applicable footwear. The Diversity Center does not provide and assumes no responsibility for personal clothing, personal camping gear and the like, and/or injury arising from the participants' lack of use, or misuse of the same.

There are no physical, emotional, or mental problems or limitations associated with my child's participation in activities, except as disclosed by me in writing attached to the medical form.

The physical rigors involved require that each participant be of sound health considering the activities involved and that acceptable certification of participation be provided by parents/guardians.

Release Provision

I, on behalf of myself and my child, hereby release and waive any claim of liability against The Diversity Center of Northeast Ohio, its agents, employees, officers, directors, successors and assigns with respect to any injury, illness, damage or death occurring to my child while he/she participates in any and all activities that are related to my child's participation. I understand that this release pertains to any negligence by The Diversity Center, its agents, employees, officers, directors, successors and assigns, as well as the negligence of any other participants to my child. I assume all risk of injury on behalf of my child.

I hereby agree to indemnify and hold harmless The Diversity Center of Northeast Ohio, its agents, employees, officers, directors, successors and assigns, with respect to any claim asserted by or on behalf of my child as a result of injury, illness, damage, or death.

Consent and Signatory Acknowledgement

Participant (including minors) – Acknowledgment of personal responsibility:
I have read and my parent/guardian has explained the terms of this agreement. I will abide by the terms of the Agreement and recognize my personal responsibility for my conduct.

Participant Signature:____________________________________ Date:____________________

Parents or Guardians (of Minors):
I have read and fully understand the terms of this agreement, and explained its terms to my child. I give my permission for my child to participate in all camp activities, including those described.

In my absence or inability to communicate with emergency and hospital personnel, I hereby grant authority to release, for the purpose of providing medical treatment, my child to the care of medical personnel or physicians as The Diversity Center of Northeast Ohio determine reasonably appropriate.

Parent/ Guardian Signature:______________________________________ Date:___________________
Note: Custodial parents or guardians must sign this form.

PARENT/GUARDIAN CONTACT:
Name____

Address____
____

Phone____
Daytime **Evening** **Cell**

DESIGNATED CONTACT (in case parent cannot be reached):

Name/Relationship____

Address____
____

Phone____
Daytime **Evening** **Cell**

STUDENT PUBLICITY RELEASE

Photographs, slides, and videotapes may be made during the duration of the retreat and participants are likely to be included in any of these. These photos, slides, and videos may be used in press releases, news stories, various Diversity Center of Northeast Ohio publicity pieces, or in similar publications. We hereby request permission to use any photographs, slides, or videotapes in which you appear for these purposes. Thank you for your consideration.

****

I give my consent to use photographs, slides, or videotapes in which I/my child appear(s) for publicity purposes.

____

PARENT/GUARDIAN SIGNATURE DATE

____

STUDENT SIGNATURE DATE

STUDENT AGREEMENT

I accept the challenge of being a participant at The Diversity Center of Northeast Ohio's amp STARR retreat. As a participant, I acknowledge my responsibility to, myself and other participants.

I agree to be present at the retreat from Tuesday, June 14, 2011, through Friday, June 17, 2011. Unless I have arranged an alternate schedule with The Diversity Center of Northeast Ohio.

I will respect the rights and responsibilities of my participation and will join in the spirit of the retreat to the best of my ability.

____

STUDENT SIGNATURE DATE

THE DIVERSITY CENTER OF NORTHEAST OHIO
STUDENT MEDICAL INFORMATION & EMERGENCY RELEASE FORM

Please print clearly. It is crucial that you complete all requested information.

____
High School

____
Student Participant

Age ________ Male _______ Female _______

Street Address _____________________________________ Home Phone ( )__________________

____
City State Zip

____
Parent/Guardian: Name Phone (home and cell)

____
Physician: Name Phone (day & night)

____
Family Dentist: Name Phone (day & night)

____
Medical Insurance - Provider & Number

MEDICAL HISTORY: **Check all that apply.**

Diseases & Immunizations

____Chicken Pox ____Mumps
____Measles ____Tetanus Booster Date _____________
____German Measles ____Tuberculin Test Date ______________
____Measles, Mumps, Rubella Date ____

Ever had a reaction to any immunization? If so, please describe:

____

Allergies:

____Hay Fever ____Insect Bites/Stings
____Asthma ____Food _________________________
____Poison Ivy, Sumac, Oak ____Medication ___________________
(type)

Currently taking medication for allergies? Please describe:

____

-continued on back-

Chronic Illnesses:

___Heart Disease ___Ear Infections
___Convulsions ___Diabetes
___Other

Please describe ______________________________

CURRENT HEALTH STATUS:

Please describe any problems or conditions that could affect participation.

____

____

Any special consideration, i.e. dietary needs, restricted activity, etc? **PLEASE SPECIFY IF YOU ARE A VEGETARIAN, VEGAN, MAINTAIN A KOSHER DIET OR HAVE FOOD ALLERGIES!**

____

Are you taking prescribed medication? If so, please list medication & dosage schedule.

____
____
____

GENERAL EMOTIONAL HEALTH:

Mini-Town is an intellectually, physically, and emotionally challenging experience for young people. To assist the staff in providing a productive, supportive environment for all participants, please respond to the following questions. All information will remain strictly confidential.

Do you have particular emotional needs about which the staff should know? If yes, please explain briefly.

____
____
____

Are you currently participating in psychological counseling? If yes, please give counselor's or physician's name, daytime and nighttime phone numbers (for emergency use only).

____

ADITIONAL HEALTH INFORMATION:

Please offer any necessary health information not included on this form:

____
____

JOY OUTDOOR EDUCATION CENTER, LLC

MEDICAL FORM & ACKNOWLEDGMENT OF RISK and RELEASE (printed on Back)

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT**

PARTICIPANT'S LAST NAME: ____________________________**FIRST:** _________________________ ___________
Circle One: Male / Female **Circle One**: Chaperone / Participant **Participant's Birth Date**: / / **Age:** ____
Street Address: _________________________________City _____________________ State__________ Zip: ______
Phone (___)____________

Primary Contact:________________________ **Relationship**: (Parent / Guardian / Spouse / Other): __________________
Primary Contact #.'s: Home: (____)__________________Work: (_____)______________Other: (_____)______________

IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)
1. Name: ____________________ Relationship: _________ **2.** Name: _______________________Relationship:_________
Address: ____ Address____
Home # (______)_________ Work # (____)__________ Home # (____)__________ Work # (____)_________

PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: ______________________________ Policy or Group #: _____________________________
Policyholders First & Last Name:_____________________ Employer:______________________________________
Primary Physician's Name:___________________________ Phone:(___)__________________________________
Family Dentist's Name:______________________________ Phone: (____)__________________________________

MEDICATIONS

Prescribed Medicine Name / Reason
1. ____ Immunizations: DPT Date______ Tetanus Date__________
2. ____ Have you had Chicken Pox? Circle: Yes No

List any dietary restrictions: ____________________________ List any activity restrictions: _________________________

List anything else, which would help us, better serve you: ____

MEDICAL CONDITIONS

- ❑ Asthma (Does participant carry an inhaler?) ____
- ❑ Broken Bones
- ❑ Diabetes
- ❑ Ear Infections
- ❑ Headaches
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Infectious Hepatitis
- ❑ Psychiatric Care
- ❑ Pregnancy
- ❑ Fainting
- ❑ Convulsions / Seizures / Epilepsy Date of last Seizure:___/____/___

ALLERGIES: Check all that apply

- ❑ Hay Fever
- ❑ Insect Stings
- ❑ Poison Ivy, other plants:______________
- ❑ Peanuts, other foods: _________
- ❑ Penicillin, Other drugs:_______
- ❑ Latex

Describe Allergic Reaction:_______________
____
____

Does participant carry an Epi-pen? _______
(If yes, please send Epi-pen with participant and ensure s/he knows how to use it safely.)

SIGNATURE REQUIRED ON NEXT PAGE

Please describe management of the above conditions / allergies:____________________
____

Describe and give dates of any hospitalizations, serious injuries or recurring illnesses:____
____

Joy Outdoor Education Center

This form should be printed on the back of the Medical Form! Each participant and/or their parent must sign this form before the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.

ACKNOWLEDGEMENT OF RISK AND RELEASE

• I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (JOEC) are based on a “Challenge by Choice” philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

• I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, and other activities at JOEC, for which I and / or my child have enrolled, entails certain risks.

• I understand that completing and signing the Center’s Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.

• Therefore, for myself / my child, I expressly, knowingly and voluntarily assume all risks involved in my participation, and do hereby release JOEC and its members, trustees, officers, employees, independent contractors and agents from any and all liability, damages, costs and expenses arising out of or relating to bodily or psychological injury, loss of life or personal property that may occur as a result of participating in this program.

• I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the said program.

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

Authorization for treatment: I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant and assist with prescription or over-the-counter medication if needed. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the visiting school or organization or JOEC to secure and administer treatment, including hospitalization, for the person named above.

NOTE: *This participant **shall not be permitted** to participate in the following activities:

____

____

REQUIRED: Signature of participant Date

____

REQUIRED: Signature of Parent/Legal Guardian (If participant is under 18) Date

Media Release: I give my consent for myself or my child to be photographed or videotaped for general camp use, Website, and/or agency publicity.

____

REQUIRED: Signature of Parent/Legal Guardian (If participant is under 18) Date