Butman Methodist Camp
2020 Camper Registration Form

Mail to: **Camp Registrar**
158 County Rd. 674
Merkel, TX 79536

Phone: 325-846-4212
Fax: 325-846-3231
Email: camp@butmancamp.org
Web Site: www. butmancamp.org

For office use only

Check # _____ $_____ $_____
Amount of check this camper
Check From: _____

Check # _____ $_____ $_____
Amount of Check this camper
Check From: _____

Registering For: Please check all Camps that apply:

Camper Fees Postmarked on or before…	February 24th	April 20th	After April 20th
☐ **New Dawn II (June 22-26)** (for intellectually challenged adults-18+)	**$290.00**	**$305.00**	**$318.00**

*****Please see www.butmancamp.org for costs, dates, and Camp Directors for each camp*****

Registrations must be completed and signed by the parent/guardian. Many churches financially help their youth pay for camp. Please contact your home church about this possibility. Please have pastor or appropriate staff person sign registration form. The signed and completed Medical Form and registration fee must accompany the Registration Form, or forms will be returned for completion.

*****Please Print Legibly***** *****Please Print Legibly***** *****Please Print Legibly*****

Camper Name _____
First (goes by) Middle Initial Last

Home Address _____
Street or Box Number City State Zip

Home Ph# (____) _____Cell # (_____)_____**Camper** e-mail_____

School Grade Entering Fall 2020_____ Age at Camp _____ Birth Date _____ Gender __ (M) __ (F)

What Church did you come to camp with? _____ Phone# (_____)_____

Church Address _____
Street or Box Number City State Zip

Pastor's Name_____ Pastor's Signature _____
(Please print)

Parent/Guardian/Mother _____ **Parent/Guardian/Father:** _____

Address_____ Address_____
(If different from Camper) (If different from Camper)

Home Ph# (____) _____ Home Ph# (____)_____

Work Ph# (____)_____ Work Ph# (____)_____

Cell Ph# (____)_____ Cell Ph# (____)_____

Parent/Guardian Email: _____

Emergency Contact: _____ **Phone** # _____

Relationship to Camper: _____Who will pick up camper _____

Does camper have an incarcerated **parent/loved one**? Yes ⬭ No ⬭

Name of incarcerated parent/loved one _____

Roommate Preference (1 **only** please) _____
(Roommate preference not guaranteed. Roommate preference not available for campers registered onsite.)

Camp Activities at **Butman Methodist Camp** may include but are not limited to: swimming, hiking, sports, water slide, group games, Ropes Course and Climbing Wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental to the camp setting and will hold the NWTX Conference, Butman Methodist Camp and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Butman Methodist Camp & Retreat Center to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, Butman Methodist Camp's social media outlets, or on the camp's web site.

Custodial Parent/Guardian's Signature _____Date_____

Please Note: **All camp fees are nonrefundable.**

Camper Medical Form

Camper Name: _____ **Camp(s) Registering For:** _____

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Immunization History: Please record the date (month/year) of basic immunizations and most recent boosters.

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – *Haemophilus influenzae* type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Hep A- hepatitis A		
MCV (Meningococcal Vaccine)		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Food Allergies
		Other Allergies

Does your child have Asthma? Yes No

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition_____

Dietary restrictions or special requests _____

Activities to be encouraged or limited _____

Current medications: PLEASE FILL OUT ATTACHED FORM.

COMMENTS: Please list any special circumstances that might affect how the camper relates to others at camp. Examples: special dietary needs, short attention span, family or personal circumstances, etc.

_____

_____

For Females: Has this person begun menstruation? _____ yes _____ no If not, has she been told about it? _____ yes _____ no

If so, is her menstrual history normal? _____ yes _____ no Special Consideration? _____

To the Best of My Knowledge _____ is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility**. I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

Custodial Parent/Guardian Signature _____ Date _____

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company _____

Policy# _____ Group# _____

Insurance Address & Phone # _____

Family Physician Name & Phone # _____

Butman Methodist Camp

Camper Medication Form for: _____(Camper's Name)

Please Note: All prescription medications must be in the original prescription containers with Camper's name and dosage clearly marked on the container. Please put dosage and at what time to give.

Important: Insulin dosages must be included and must be clearly readable. Make sure the medication name matches what is on the bottle

Medication Name/mg	Dosage	Before Breakfast	Breakfast	Lunch	Afternoon	Dinner	Evening
EXAMPLE: BENADRYL	12mg	1 tab					2 tabs
EXAMPLE: TYLENOL	10mg	AS NEEDED					

CAMP NEW DAWN II HEALTH EXAMINATION FORM

RETURN TO: Butman Camp Registrar

158 CR 674

Merkel, TX 79536

Please have parent/guardian and physician complete appropriate sections of this form **in full** before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Camper Name:_____ Date: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

***This section must be filled out before form is considered complete.**

Is camper on a special diet? ____ Yes ____ No Explain _____

Is camper on any special medicine? ____ Yes ____ No Explain _____

Is camper on any new medication? ____ Yes ____ No Explain _____

Is medicine being sent by parent/guardian? ____ Yes ____ No Explain _____

Restrictions on swimming, diving? ____ Yes ____ No Explain _____

Restrictions on strenuous activity? ____ Yes ____ No Explain _____

Is camper able to dress self? ____ Yes ____ No Explain _____

Is camper able to sleep in an upper bunk? ____ Yes ____ No Explain _____

Is camper able to talk? ____ Yes ____ No Explain _____

Does camper walk well? ____ Yes ____ No Explain _____

Is camper an early riser? ____ Yes ____ No Explain _____

Does camper wet the bed? ____ Yes ____ No Explain _____

Does camper smoke or chew tobacco? ____ Yes ____ No Explain _____

Is camper able to read? ____ Yes ____ No Explain _____

Does camper have incontinence problems? ____ Yes ____ No Explain _____

Is camper a sleepwalker? ____ Yes ____ No Explain _____

Does camper wear protective garments (i.e. Depends) ____ Yes ____ No Explain _____

Campers T-Shirt Size S M L XL XXL
Other _____

	Totally Independent	Partially Independent	Dependent
Brush Teeth			
Bathing			
Dressing			
Eating			
Toilet Usage			

PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician. **In the event that I cannot be reached in an EMERGENCY**, I hereby give permission to the physician, selected by the camp director, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Parent/Guardian Signature: _____ **Date:** _____

MEDICAL EXAMINATION
To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. **You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below.** Examinations are necessary for determining fitness/ability to engage in all activities.

CODE: S – Satisfactory U - Unsatisfactory (Explain) O - Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes _____ Extremities _____

Glasses _____ Posture (spine) _____

Ears _____ Skin _____

Nose _____ Allergy-Please specify: _____

Throat _____ _____

Teeth _____ _____

Heart _____ _____

Lungs _____ General Appraisal: _____

Abdomen _____ _____

Hernia _____ _____

*(For girls and women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

_____

_____

Comments: _____

_____

_____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician Signature: _____ **Date:** _____

Address: _____ **Telephone:** ( ) _____

Camper's Name: _____**Date Examined:** _____ **Cabin #** _____ **Year:** _____