Wings to Soar Camp - Cabarrus Application

CHILD/TEEN REGISTRATION

*****Pre-registration for Wings to Soar Camp is required*****

Application will be denied if not filled out completely.

For each child who will be attending, please send this completed registration form to:

Shea.Collins@AtriumHealth.org or mail it to:

Hospice & Palliative Care of Cabarrus County - (Attn: Wings to Soar) - 5003 Hospice Ln, Kannapolis, NC 28081

CAMPER INFORMATION

Name: _____

Last *First* *MI*

DOB: _____ Sex: _____ Age:_____

Prefers to be called: _____

Parent or Guardian: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Camper T-shirt Size: Adult / Child (Circle One) Small / Medium / Large / XL / XXL (Circle One)

School: _____

Grade: _____

PARENT INFORMATION

*Parents/guardians are recommended to participate in the adult session while the child is at camp.

Primary Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Contact information for parent living away from primary home:

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Wings to Soar

Kannapolis Cannon Ballers

Atrium Health

Wings to Soar Camp - Cabarrus
Children's Medical Information

Please complete both sides of this form.

NOTE: This form is given to and reviewed by our camp nurse, therefore must be filled out in its entirety prior to acceptance of camper application.

MEDICAL INFORMATION

List any physical or mental concerns your child may have: _____

_____

Are there any activities that should be restricted? _____

_____

List any medications that are taken. (If necessary, medications will be dispensed by the Camp Nurse).

Medication Taken	Dose	Time Taken
_____	_____	_____
_____	_____	_____

List any allergies that we should know about (ex. Hay Fever, Insect Stings, Penicillin, Asthma etc.):

_____

List any food allergies or diet restrictions:

_____

Is camper up to date with all immunizations? _____

Health Insurance: _____

Name of Insured: _____

Policy Number: _____

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IN CASE OF EMERGENCY, THE CAMP SHOULD NOTIFY

If the parent/guardian is not available in event of an emergency, please notify:

Name: _____ Home Phone: _____

Cell Phone: _____

Relationship to Camper: _____

Secondary responsible party to notify in case we cannot reach the person listed above:

Name: _____ Home Phone: _____

Cell Phone: _____

Relationship to Camper: _____

Primary Physician: _____ Phone: _____

Name of Practice: _____

Dentist: _____ Phone: _____

IMPORTANT --THIS SECTION MUST BE COMPLETED FOR ATTENDANCE!!

This health history is correct as far as I know, and the child herein described has my permission to engage in all prescribed camp activities except those expressly noted herein.

AUTHORIZATION FOR TREATMENT:

I hereby give permission to the camp medical personnel to release medical history information, to contact the primary care physician and/or dentist, and/or to provide or arrange related transportation for my child named herein in case of emergency to the nearest medical facility. In the event, I cannot be reached in an emergency, I hereby give permission to the camp medical personnel to secure and administer treatment, including hospitalization for my child. I understand that no accident or medical insurance is provided and agree that I will be financially responsible for any medical treatment received by my child.

Signature of Parent or Guardian _____

Date _____

LIABILITY RELEASE:

I hereby release Wings to Soar Camp, Hospice & Palliative Care of Cabarrus County and its parent, predecessors, successors, subsidiaries, assigns, affiliates, related entities, divisions, directors, officers, commissioners, members, employees, volunteers, agents, attorneys, representatives, heirs and assigns from and against any and all claims, damages, liability, costs, or demands, arising from or relating to my child's participation in Wings to Soar Camp including, without limitation, any personal injury or property damage that my child may sustain, however caused and whenever realized.

Signature of Parent or Guardian _____

Date _____

Wings to Soar

KANNAPOLIS Cannon Ballers

Atrium Health

CAMPER LOSS

Name of deceased person: _____

Relationship of deceased to child: _____

Was deceased a Hospice & Palliative Care of Cabarrus County patient? ☐ Yes ☐ No

Did the child live with the deceased? ☐ Yes ☐ No

Date of death: _____ Deceased age at death: _____

Type of death: ☐ Accident ☐ Long term illness ☐ Short term illness ☐ Traumatic (Murder/Suicide)

Please explain: _____

_____

_____

_____

Was the child present with the deceased at the time of death: ☐ Yes ☐ No

Other significant losses/changes in the past 2 years: _____

_____

_____