



# Community Healthplex

Registration Form

Camp 2018

### Camper's Information

Last Name		First Name		Middle Initial	Birthdate
Home Address			City	State	Zip Code
Male	Female				YES NO
Childs' Gender	Shirt Size (Youth S, M, L, XL, Adult S, M, L, XL)			Healthplex Member?	

### Parent Information

Last Name		First Name		Middle Initial	Relationship
					H C W
Home Phone		Cell Phone		Work Phone	Best Way to Contact
E-Mail Address					

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Last Name		First Name		Middle Initial	Relationship
					H C W
Home Phone		Cell Phone		Work Phone	Best Way to Contact
E-Mail Address					

### Camper's Health and Additional Information

Allergies			
Food Sensitivities			
Medical Conditions			
Current Medication			
Physician's Name	Physician's Phone	Dentist's Name	Dentist's Phone

Please list any additional information (i.e.: special needs) that you feel would be helpful to the Community Healthplex Staff. We want your child's experience to be positive and fun. Any suggestions and or tips will be taken into consideration.

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### Emergency Contact and Pick Up Authorization

Please list, in order, all persons to be used as an emergency contact in the event the previous listed parent/guardian cannot be reached. Those listed below are also authorized to pick up your child. Anyone not on this list will not be authorized to sign out the child from Community Healthplex Camp. Anyone listed must provide a valid photo I.D. at time of pick up and must be 16 years or older. Any changes or additions to this list must be made in person by the parent or guardians listed above.

Authorized Pick-Up Name	Relationship	Phone	Phone
Authorized Pick-Up Name	Relationship	Phone	Phone
Authorized Pick-Up Name	Relationship	Phone	Phone
Authorized Pick-Up Name	Relationship	Phone	Phone

### Payment Information

Payment is due in full at the time of registration. If payment is not received in full by Monday at 6:00 pm, the card on file or membership account will be charged if the camper attended the registered week. All campers must provide a credit card at the time of registration and that information will be kept on file for the duration of camp. Members may provide an additional payment form if different from your payment information on file for membership. It is your responsibility to notify us of any unattended days within two weeks in order to be designated a refund.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date
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### Camper's Behavior

Our goal is for each camper to have a positive and enjoyable experience while at Community Healthplex Camp. If at any time a camper's behavior interferes with the other campers' experience, our camp counselors will reiterate the daily expectations and encourage a positive experience for everyone. Should this disruptive behavior continue, a counselor will remove the camper from the situation and discuss their behavior. Disciplinary action (i.e. a deduction of a favorite activity, time-out or loss of free time) may result if the disruptive behavior continues. If the situation remains unresolved, the camp leaders will be called to the situation. The camp staff will decide what the next steps should be. A phone call to the parent may be made to ask for assistance in determining a solution for the behavior. If the plan for behavior change does not work, the camper may be asked to leave the camp program.

There are certain behaviors that have a zero tolerance policy. These behaviors include, but are not limited to: repeated insubordination, possession of a weapon or dangerous material, possession of an illegal substance, sexual or verbal abuse, inappropriate contact with another camper or counselor, leaving camp without permission, and harm to self or others.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date
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### Camper's Belongings

We strongly discourage campers bringing valuables, electronics, toys, gum or candy. Campers will not be allowed to use any electronics during the camp day. Should contact need to be made with a parent or guardian, it will be done so using a Community Healthplex phone. **Community Healthplex is not responsible for any lost or stolen items.**

Parent/Guardian Printed Name	Parent/Guardian Signature	Date
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# Community Healthplex

**CHILD'S PHYSICAL CONDITION AND EXPECTED BEHAVIOR:** I hereby declare my child to be physically sound, having medical approval to participate in the activities of the Community Healthplex Camp. The health history is correct so far as I know, and my child has permission to engage in all prescribed activities except as noted in the special needs section above. I understand it is my responsibility to promptly notify my child's camp director in writing of any changes in my child's health. I certify that my child is amendable to discipline and free from habits or attitudes which would make him/her an undesirable participant.

**MEDICAL PERMISSION:** Community Healthplex staff does not provide any over-the-counter medicine to the participants of the Community Healthplex Camps. If deemed by the camper's parent, distribution of prescribed medication may be administered by a camp counselor. Medication must be dropped off in its original container with the campers name, distribution time and dose labeled.

**EMERGENCY AUTHORIZATION:** I hereby give permission to the medical personnel attending to my child to order X-rays, routine tests and treatment for my child, and in the event I am not able to communicate or cannot be reached in an emergency, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injections, and/or anesthesia and/or surgery for my child as named above. I will be fully responsible for any costs of such treatment, even if not covered by insurance. In the event that a camper is severely injured, ill and/or contagious to fellow campers, parents/guardians will be contacted via phone.

**RELEASE AND WAIVER:** In consideration of my child's participation in the activities of the Community Healthplex Camp (including field trips and transportation provided by third parties) and acknowledging that risk of injury exists, **I hereby release, waive, discharge, covenant not to sue and agree to hold harmless Community Health Network and Community Healthplex and their officials,** heirs, assigns, representatives, officers, members, independent contractors employees, and volunteers from any and all claims or liability for personal injury or property damage my child or I may suffer directly or indirectly arising out of or relating in any respect to participating in Community Healthplex Camp. This waiver and release of all claims, demands, action and liability shall include, without limitations, any injury, damage or loss to person or property which may be (a) caused by any act or failure to act by Releases even if said injury, damage or loss results from the negligence of any or all of the above identified Releases or (b) sustained by me before, during or after Community Healthplex Camp.

**I agree to indemnify and hold harmless Community Healthplex from all lawsuits, losses, damages, claims and expenses, including attorney's fees and costs arising from or relating to in any respect to my child's participation in Community Healthplex Camp or my breach of all terms and conditions contained in the Community Healthplex Camp Registration Form.** This provision will apply regardless of whether or not the lawsuit, losses, damages claims, expenses, attorney's fees and/or costs arises out of the negligence of Community Healthplex.

The law of the State of Indiana will govern any disputes/ matters relating to this Consent and Liability Release.

I certify that I am the parent/legal guardian of this child and that I have authority to make the representations and grant the authorizations continued herein. I have read and fully understand the terms and conditions of participation in the Community Healthplex Camp.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

### **Publicity (Photo and Video Release)**

Photos are periodically taken of participants in the Community Healthplex Camp. Please be aware that these photos are the property of Community Healthplex and may be used in the department's publications, website and video production unless you elect not to give permission for the use of your child's likeness. **I consent to such uses and waive any right of privacy or publicity I may have in connection with those uses. Failure to complete this section will be considered permission.**

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

**"About Me"**

This section is to help our camp staff get to know your camper! Please complete the questions below for your child or with them. We appreciate any feedback or helpful tips about your camper.

What are some of the things that you are most interested in?

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What upsets you?

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What are you afraid of?

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What makes you laugh?

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What is ONE thing you would like to get better at this summer?

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What calms you down when you are overwhelmed or upset?

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What rewards work well for you?

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What do you do for fun?

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Person Completing this form

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Relationship to camper:

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# ELECTRONIC FUNDS TRANSFER (EFT) PAYMENT PROGRAM AUTHORIZATION

Community Healthplex membership includes access to a house charge account to be used for service and Pro Shop purchases during the month. The Electronic Funds Transfer (EFT) system retains Credit Card or banking information that is processed at the end of each billing period to pay the balance on this account via Credit Card charge or Automated Clearing House (ACH) bank transfer.

Please select one of the following options authorizing Community Healthplex located at 3660 Guion Rd., Indianapolis, IN 46222 to pay off the accumulated balance on your house charge account at the end of each billing period.

## Account Holder Information

Name(s)

Account Holder Phone

Account Holder Address

City

IN

ST

Zip

Please check the box next to ONLY ONE of the options below and fill out information for authorization.

### Authorization for Checking/Savings Account (ACH)

Account Holder's Bank Name

Branch City

ST

Zip

Bank Routing Number (9 digits)

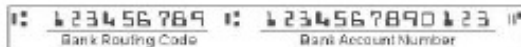
Bank Account Number

Account Type:

Business Checking

Personal Checking

Savings



How to find your Routing and Account Numbers on a check

Recurring

Monthly

Open Ended

ACH Type

Frequency

Number of Payments

Variable

Amount per Payment

I hereby authorize the Community Healthplex to Debit the Bank Account referenced herein, via the Automated Clearing House (ACH) system, according to the parameters specified herein. This authority will remain in effect until the payment(s) are completed as specified herein. If a payment is returned for any reason I acknowledge that I am subject to a rejected item fee of \$25 or the maximum amount allowed by law.

### Authorization for Credit Card EFT

Print Name (as it appears on your card)

Credit Card Number

Card Expiration Date

Card Type:  Visa

Master Card

AMEX

Discover

## Authorization

Signature of Account Holder

Print Name of Account Holder

Date