

Orlando Conference 2010

Signs and Wonders Conference Registration—Part A



Orlando
House of Prayer

Child Name

Last	First	Middle	<input type="checkbox"/>	F	<input type="checkbox"/>	M
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Child prefers to be called: _____

Citizenship (Please select one):

<input type="checkbox"/> USA Citizen	<input type="checkbox"/> USA National	<input type="checkbox"/> Legal Permanent Resident
<input type="checkbox"/> Currently not living in the USA	<input type="checkbox"/> Legally present in the USA: Type of visa: _____	

Date of Birth _____ / _____ / _____
Month Day Year

Age as of 9/01/10: _____

Father's Full Name _____

Mother's Full Name _____

Home Phone Number
() _____

T-Shirt Size Check ONE
Child's __XS __S __M __L __XL
Adult __XS __S __M __L __XL __XXL

Father's Cell
() _____

Mother's Cell
() _____

Family Email Address _____

Family Address _____

If parents have separate addresses and would both like to be contacted please indicate:

Father Mother

Does your child have any physical disabilities or conditions that require special care? Y N

If yes, Please include details typed on a separate sheet of paper.



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Emergency contact 1

Name: _____

Relation to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Emergency contact 2

Name: _____

Relation to child: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Pick up Authorization *Please note:* Photo identification is required at the time of pickup.

If you or an emergency contact will not be picking up your child: I give permission for _____

To pick up _____ (Childs Name).

Please list any persons your child is **not** allowed to leave with: _____

Additional Information — Part B

We will always attempt contact with parents first. In the event you cannot be reached, who may we contact?

How did you find out about SWC?

Online Mailing

Email Friend

Other _____

How many past conference's at OHOP?IHOP has your child attended? _____

What factors played a role in your decision to send your child to SWC?

Select all that apply

My child chose this conference Curriculum

Location was convenient Dates worked well for our family

Commitment & Agreement — Part C

Please acknowledge your agreement with the following statements by initialing each of the boxes and signing your name:

Parent Agreement:

___ I agree that to the best of my knowledge and belief that the facts I have provided to support this application are true, correct and complete

___ I give full permission for my child to attend the event and activities for which he/she has registered.

___ I give full permission for my child to participate in all activities unless otherwise noted on 1st page of Health Form.

___ I give full permission for my child to have photo used in publicity photos, films and videos. (No names or personal info will be used.) The undersigned releases and forever discharges OHOP, IHOP-KC Missions base, its agents, officers and employees from any and all claims and demands arising out of or in a connection with the use of said photographs/ images, including but not limited to, any claims for invasion of privacy or defamation.

Parent/Legal Guardian Signature

Date

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Health forms Part D



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Childs Name

Last First Middle

Child prefers to be called: _____ M F

Date of Birth ____/____/____

Age as of 9/01/10: _____

Any recent illness/injury? What/When: _____

Any special challenges? (ADD, Behavior disorders, physical/mental conditions, Special diet needs, etc.) _____

Date of last physical _____

Date of last tetanus shot _____

Restrictions

On activities

- _____ None
- _____ Strenuous games
- _____ Other (Explain)

Allergies

- _____ Insect sting/bite
- _____ Hay fever
- _____ Penicillin
- _____ Poison Ivy/Oak
- _____ Sulfa/other drugs
- _____ Tetanus shot
- _____ Other (explain)

Has History of/Under

Medical Care for

- _____ Appendicitis
- _____ Asthma
- _____ Bronchitis
- _____ Diabetes
- _____ Seizures
- _____ Heart trouble
- _____ Hernia
- _____ Nervous disorder
- _____ Psychological disorder
- _____ Skin Disease

Does child wear

- _____ Contact lenses
- _____ Glasses
- _____ Hearing aid
- _____ Orthodontics

Subject to

- _____ Cold/Pneumonia
- _____ Convulsions
- _____ Cramps
- _____ Dehydration
- _____ Earaches
- _____ Exhaustion
- _____ Fainting

- _____ Headaches
- _____ Nose-Bleeds
- _____ Sore Throats
- _____ Toothaches
- _____ Stomach/digestive

Disorder

- _____ Other

EMERGENCY CARE AUTHORIZATION

I, _____, Parent/Guardian of the above name

Minor, I will not hold Orlando House of Prayer or its staff responsible for any injuries or damages related pursuing such emergency medical treatment. I also give permission for my child (ward) to participate in activities with restrictions as indicated as indicated in column to the left. I declare that the health information I have provided in this Application, to the best of my knowledge and belief, is true, correct, and complete.

Parent Signature: _____ **Date:** _____

Home ph: _____ Day ph: _____

Emergency Contact— In case parents cannot be reached. SWC will attempt to reach Emergency contact 1 and/or Emergency Contact 2 listed on pg. 4

Other Health Information: _____

Which of the following

has the Participant had?

- _____ Measles
- _____ Chicken Pox
- _____ German Measles
- _____ Mumps

- _____ TD (Tetanus/diphtheria)
- _____ Polio _____ Meningitis
- _____ MMR
- _____ or Measles
- _____ or Mumps
- _____ or Rubella

Immunizations Optional

Please list Month and Year

_____ DTP

- _____ Heamophils influenza B
- _____ Varicella (Chicken Pox)
- _____ Hepatitis

Health Forms Part E



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Insurance & physician if available

Policy holder's name: _____ Doctor's Name: _____

Policy Number: _____ Doctor's phone number: (____) _____

Insurance company & phone: _____ (____) _____

Medication Policy

Children will be allowed to self-administer any **scheduled** or **prescription (s)** as needed medication under the Nurse while at SWC this summer. **Counselors will not be allowed to give children their medicine;** however, they will supervise to ensure that the child is taking only his or her medication. This means that your child will be responsible for taking their medication while supervised by a nurse. After the medication is checked by the Nurse it will be kept with the nurse in a secure location at all time. **The children will then be responsible for ensuring that they take their own medications.**

- **Please place ALL medication in a clear zip lock bag with your child's first and last name, date of birth, and if the medication is scheduled or as needed so it can be clearly seen and read**
- Children will be allowed to keep inhalers, epi-pens, (**Must be in original bottle** as to be identifiable by the Nurse).
- All medicine needs to be in the **original packaging** even if it is an over the counter medicine. Prescription medication needs to come in the **ORIGINAL** bottle.
- If your child takes a scheduled over the counter medicine like Zyrtec you need to make sure that you write SCHEDULE on the outside of the zip lock bag or on the medicine container. They can only take a medicine as needed if it is a prescription medication and it comes in the original bottle with instruction.

There will be a nurse available during the day to ensure that if your child needs any medical attention it will be addressed in a timely fashion.

As the legal guardian or parent of _____ (Child's name) I consent to allowing my child to self administer any scheduled medication that they may bring to SWC under the supervision of a nurse. I have sent medication in the original packaging. I have read the above and understand the policy and procedure for my child taking their medication during SWC.

Parent/Guardian Signature

Date:

We will have a community supply of many of the common over the counter medicines like Tylenol, Ibuprofen, & Benadryl on hand to be administered by a nurse as necessary. Please provide written consent for common over the counter medicines to be given to your child based on the labeled dosing and weight of your child as deemed necessary by a nurse if needed. Only send over the counter medication with your child if you feel we will not have it on hand.

Please check:

- Yes, I approve a nurse providing common OTC's to my child as needed. With the exception of _____
- No, I do NOT approve of the nurse giving my child OTC's without my verbal consent for which I am providing a number where I can be reached easily.

Please provide two telephone numbers below if you answered NO

1. (____) _____ 2. (____) _____

Parent/GUARDIAN Signature

Date

Health Forms— Part F



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Please have all medication (s) in the original container (s). Fill out all information below and please **PRINT LEGIBLY.**

Child's name (First and Last): _____

How many prescriptions medications are you sending with your child? _____ (Please list them below) I,

_____, The parent/legal guardian of the above child give the Nurse permission to supervise the above child as they administer their own medication.

Parent/Legal Guardian Signature: _____ Date: _____

Medication	What is medication for?	Does medication need To be refrigerated?	How should medication be administered?	**For office use only** Record times given below
1.		Y/N	Dosage? _____ How many times? _____ With meals? Y/N Only with water? Y/N	Day 1 _____ _____ Day 2 _____ _____ Day 3 _____ _____
2.		Y/N	Dosage? _____ How many times? _____ With meals? Y/N Only with water? Y/N	Day 1 _____ _____ Day 2 _____ _____ Day 3 _____ _____
3.		Y/N	Dosage? _____ How many times? _____ With meals? Y/N Only with water? Y/N	Day 1 _____ _____ Day 2 _____ _____ Day 3 _____ _____
4.		Y/N	Dosage? _____ How many times? _____ With meals? Y/N Only with water? Y/N	Day 1 _____ _____ Day 2 _____ _____ Day 3 _____ _____
5.		Y/N	Dosage? _____ How many times? _____ With meals? Y/N Only with water? Y/N	Day 1 _____ _____ Day 2 _____ _____ Day 3 _____ _____