Royal Retreat 2023

September 30—October 1

Friday night through Sunday afternoon

for Students Ages 11-14

Return Completed Application:
South Cleveland Church
P.O. Box 2081
Cleveland, TN 37320

silverpam4@gmail.com

Questions?
Call Pam Silver 423-284-3826

REGISTRATION FORM

Instructions: *Please Print.* This form must be completely filled out.

_____

Student's Last Name First Name Preferred Name Sex Birthdate

_____

Street City ZIP

_____

Age Emotional Age Grade School

The child is living with: (Check one) __Foster parent __Group home __Parent __Other relative __Adoptive parent

_____

Name(s) of person(s) the child is living with

_(_____)_____ (_____)_____

Cell phone Home or Work Phone

_____(_____)_____

Emergency Contact (Other than person living with) Phone

_____

Relationship to Child

_____(_____)_____

Social Worker Day Phone Number

Explain any unusual family circumstances that make retreat especially important for the child:
(For example: recent crisis, moving to new home, severe economic needs, etc.)

_____

_____

STUDENT'S EMOTIONAL/BEHAVIORAL HISTORY

	Often	Sometimes	Not at all		Often	Sometimes	Not at all
Aggressiveness	__	__	__	Night Terrors	__	__	__
Bedwetting	__	__	__	Nightmares	__	__	__
Biting	__	__	__	Runs Away	__	__	__
Eating Disorders	__	__	__	Sexual Acting Out	__	__	__
Hyperactive	__	__	__	Steals	__	__	__
Learning & Disabilities	__	__	__	Tantrums	__	__	__
Lying	__	__	__	Withdrawn	__	__	__

Details from above/other concerns (Please explain check marks that are sometimes or often):_____

_____

_____

CAMPER DETAILS:

Learning Disabilities: ❑ Yes ❑ No Reading Level:_____

Camper T-Shirt Size: ❑ Child Large ❑ Adult Small ❑ Adult Medium ❑ Adult Large ❑ Adult XL

HEALTH HISTORY

Indicate all known allergies, illness, disabilities, physical limitations, or medical complications:

Allergies: _____

Illnesses/medical complications:_____

Disabilities/limitations:_____

❑ Leg or Arm Braces ❑ Hearing Aids ❑ Eating Disorder

Indicate date of illness, severity, complications, and any residual impairments:

Respiratory Problems	_____	Hypoglycemia	_____	Musculoskeletal Allergies	_____
Heart or Circulation	_____	Dizzy Spells	_____	Foot	_____
Pulmonary Edema	_____	Back	_____	Seizure Disorders	_____
Hay Fever	_____	Anaphylactic Shock	_____	Poison Oak	_____
Balance Problems	_____	Diabetes	_____	Fainting	_____
Insect Bites	_____	Drug Allergy	_____	Other	_____

Details from above:_____

_____

Any specific activities to be encouraged?_____

Any specific activities to be restricted?_____

PRESCRIPTION MEDICATIONS: *All medication sent to camp must be in original container with the pharmacy label on it.*

Is your child taking any medications? ❑ No ❑ Yes, please fill in the following

1. Name_____Dosage:_____Times:_____
2. Name_____Dosage:_____Times:_____
3. Name_____Dosage:_____Times:_____
4. Name_____Dosage:_____Times:_____

What is (are) the medication(s) for:_____

Doctor's Name_____Phone_____

I understand that it is my responsibility as caregiver to make sure that all instructions are clear, and that the necessary dosage is adequately supplied for the duration of camp. I hereby authorize the retreat nurse to administer the above medication from October 21-23, 2022.

_____ _____ _____

Parent or Legal Guardian Signature Printed Name Date

MEDICAL RELEASE FORM:
This health history is correct so far as I know, and the above-named minor has permission to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of Royal Connection Retreat or such substitute as they may designate as agent for the undersigned to consent to an x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is enroute to and from or involved or participating in any retreat program.
I give my permission for _____ to attend Royal Connection Retreat sponsored by South Cleveland Church of God.

_____ _____ _____
Authorized Signature Printed Name Date

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

I hereby give the retreat's registered nurse permission to administer the following products according to manufacturer's instructions, or as otherwise specified.

I trust the nurse to use her best judgment as situations arise, and if in doubt, she can call for verification.

Please check YES or NO for the medications listed below. This form must be completed by the primary caregiver who signs below.

YES	NO		Specify if desired:
❑	❑	Sunblock	_____
❑	❑	Insect repellant	_____
❑	❑	Lip balm	_____
❑	❑	Rash ointment	_____
❑	❑	Tylenol	_____
❑	❑	Antiseptic ointment	_____
❑	❑	Band-aids	_____
❑	❑	Anti-itch cream	_____
❑	❑	Hydrogen peroxide	_____
❑	❑	Cough syrup	_____
❑	❑	Cough drops	_____
❑	❑	Decongestant	_____
❑	❑	Antihistamine	_____
❑	❑	Ipecac syrup	_____
❑	❑	Other	_____
❑	❑	Other	_____
❑	❑	Other	_____
❑	❑	Other	_____

Parent or legal guardian's signature: _____

Printed name: _____ Cell number:_____

Another person authorized to pick up student: _____ _____

PLEASE NO CAMERAS OR MONEY. THESE ITEMS ARE NOT NEEDED AT RETREAT.