

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## Harrisburg Area Confirmation Camp Registration Form June 21-27, 2026

Home Congregation \_\_\_\_\_ Pastor/Representative \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Youth Phone \_\_\_\_\_  Home  Cell

Youth Email \_\_\_\_\_ Current Grade in School ('25-'26 School Year) \_\_\_\_\_

**Are you baptized?**  Yes  No

Date of Baptism \_\_\_\_\_

**Adult Shirt Size:**

Small  Medium  Large

X-Large  XX-Large

Parent/Guardian Name(s) \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Primary Phone \_\_\_\_\_  Home  Cell 2<sup>nd</sup> Phone \_\_\_\_\_  Home  Cell

Email \_\_\_\_\_

**Additional Adult Contact Person (In Case of Emergency):**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

I request that my child's photo NOT be used in any promotional material for Confirmation Camp.

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Harrisburg Area Confirmation Camp**  
***Acknowledgement of Risk, Release and Hold Harmless Agreement***  
*(If Participant is Under 18 Years of Age)*

Name of Participant (Minor): \_\_\_\_\_

On behalf of the Participant, the parent or legal guardian of the Participant agrees as follows:

1. Assumption of Risk. I understand that participation in the Harrisburg Area Confirmation Camp (HCC) involves physical activities, including, but not limited to swimming, outdoor games, ropes course and other outdoor camping activities as part of its outdoor ministry program. I understand that these activities involve risk of injury, and I knowingly and voluntarily assume the risk of engaging in activities on behalf of the Participant. On behalf of the participant, I understand that participation may include activities which may be hazardous and that these potential dangers are part of and inherent to HCC's program. In some instances, the activities cannot be made safer. I expressly assume the risk of injury or harm in these activities and voluntarily agree to the terms of the Release as stated below. I further promise and agree to follow and to comply with all instructions of HCC and its staff, employees, and authorized representatives.
2. Waiver and Release. In consideration of the opportunity to participate in the HCC programs and in recognition of the nature of certain of activities, the Participant specifically waives any and all claims, suits, causes of action, actions, rights, expenses, damages of any kind, in law or in equity, for any and all injuries that may arise during, result from, or be otherwise connected with Participant's participation in HCC's programs. For those same reasons, Participant further remises, releases, quitclaims and forever discharges the HCC, its Board of Directors, officers, employees, staff, volunteers, agents, and representatives from any and all liability.
3. I authorize the HCC and its representatives to obtain any medical treatment for the named Participant that should appear necessary during his or her participation in the HCC and that I will be responsible for the payment of any expenses associated with the related illness or injury.
4. I agree and certify that I voluntarily signed this Agreement and I have read and fully understood the meaning of each of the terms of this Agreement. I intend to be legally bound by the terms of this Agreement.

Name of Parent or Legal Guardian (PRINT) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Legal Guardian on Behalf of Participant \_\_\_\_\_

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### Medical Information

**Allergies:**  No known allergies  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
Please describe below what the camper is allergic to, and the reaction seen:

**Diet/Nutrition:**  Regular Diet  Special Diet  Lactose intolerant  Gluten intolerant  
Please describe below any special diet/nutritional needs of the camper:

**Restrictions:** The camp week is a very active and engaging week for all participants. Please describe below any physical restrictions or adaptations the camper may need:

*If there are significant restrictions, please complete the Accommodations Form for Special Needs found on [harrisburgconfirmationcamp.org](http://harrisburgconfirmationcamp.org).*

**Over the counter medications:** The following non-prescription medications may be stocked in the Nurses' Cabin and are used on an as needed basis to manage illness and injury. **Cross out the medications the camper should NOT be given.**

- |  |  |
|--|--|
| <input type="checkbox"/> Acetaminophen (Tylenol)   | <input type="checkbox"/> Aloe                      |
| <input type="checkbox"/> Antibiotic cream  | <input type="checkbox"/> Calamine lotion           |
| <input type="checkbox"/> Antihistamine/allergy medicine  | <input type="checkbox"/> Generic cough drops       |
| <input type="checkbox"/> Diphenhydramine antihistamine/allergy medicine (Benadryl)                       | <input type="checkbox"/> Ibuprofen (Advil, Motrin) |
| <input type="checkbox"/> Antidiarrhea medicine (Kaopectate, Imodium, Pepto-Bismol)                       | <input type="checkbox"/> Sore throat spray         |
| <input type="checkbox"/> Guaifenesin cough syrup/Dextromethorphan cough syrup (Robitussin/Robitussin DM) |  |
| <input type="checkbox"/> Phenylephrine decongestant/Pseudoephedrine decongestant (Sudafed PE/Sudafed)    |  |

**Date of your child's last tetanus shot** \_\_\_\_\_

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### Medical Information

Is your child taking any medication?    Yes    No

Medications should be brought to camp in the original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. All medications must be turned over to the Camp Nursing Staff when you register and will be returned at the end of the week.

Name of Medication	Date started	Reason for taking it	When is it given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |  |  |
|--|--|
| <p>1. Ever been hospitalized?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Ever had surgery?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have recurrent/chronic illnesses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Had a recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Had a recent injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Had seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Had headaches, fainting, or dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Ever had back or joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

**Please explain "Yes" answers in the space below, noting the number of the question(s).**

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Mental, Emotional, and Social Health: Check “Yes” or “No” for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.....  Yes  No
2. Ever been treated for emotional or behavioral difficulties?.....  Yes  No
3. Ever been treated for an eating disorder?.....  Yes  No
4. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
5. Had a significant life event that continues to affect the camper’s life?.....  Yes  No  
(History or abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain “Yes” answers in the space below, noting the number of the question(s).**

**What have we forgotten to ask?** Please provide in the space below any additional information about the camper’s health that you think is important or that may affect the camper’s ability to fully participate in the camp program. Please include any information we may need to help your child have the best week.

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### Medical Insurance Information

Name of Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ HMO Plan  Yes  No

Name of Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_

Place of Employment \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Note:** In the event of an emergency illness or injury requiring medical attention, the parents' insurance will provide the primary coverage.

**To Parent or Legal Guardians:** Your signature below gives your child permission to attend Harrisburg Area Confirmation Camp and authorizes the Director or their representatives to secure proper diagnosis and treatment for any emergency illness or injury from a local hospital and/or physician.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_