

# 2025 JOY Camp Registration Form

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\_\_\_ JOY Camp #1 (June 5-8) \_\_\_ JOY Camp #2 (July 10-13)

## Participant Information

Participant First & Last Name: \_\_\_\_\_ M / F Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent's/Guardian's Full Name: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Home Congregation & City: \_\_\_\_\_ T-Shirt Size S M L XL XXL XXXL

**Y or N** Will Camp Okoboji need to bill your church for any financial assistance? If so, how will they be contributing? \_\_\_\_\_

Roommate Request: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

List the full names of adults authorized to sign your camper out at the end of the session: \_\_\_\_\_

## Terms Of Agreement

I hereby enroll and give permission for this camper to participate in the activities of this Camp Okoboji Program. I acknowledge that this camper's participation in this program involves risk, and may result in various types of injury including, but not limited to, the following: sickness, exposure to an infectious/communicable disease, contraction of an infectious/communicable disease, bodily injury, death, emotional injury, personal injury, property damage, and financial damage. I accept personal financial responsibility for any of this camper's injury or other loss sustained during this program, as well as for any medical treatment rendered to this camper that is authorized by Camp Okoboji - LCMS's staff, volunteers, or any other representatives. Further, I release Camp Okoboji - LCMS of liability and promise to defend and hold harmless Camp Okoboji - LCMS, Camp Okoboji's Board of Directors, camp staff, and volunteers for any sickness, exposure to an infectious/communicable disease, contraction of an infectious/communicable disease, injury, damage, or death arising directly or indirectly out of this camper's participation in this program. I give permission and consent for this camper to be included in photographs and videos taken during this camp session. I further give consent that any such images, videos, and interviews may be published and used to illustrate and promote Camp Okoboji - LCMS and the National Lutheran Outdoors Ministry Association. I hereby give permission for my child/youth/camper to ride in any vehicle driven by an approved and licensed adult chaperone while attending and participating in activities sponsored by Camp Okoboji - LCMS that are offsite.

Primary Contact Printed Name: \_\_\_\_\_

Primary Contact Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Camp Okoboji Health Form

This form must be on file with Camp Okoboji prior to participation in any programming.

Participant's First & Last Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Camp Program Attending \_\_\_\_\_ Dates of Camp \_\_\_\_\_

E-mail Address \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Mother's Full Name (if under 18) \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Full Name (if under 18) \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ In case of emergency, who should we call first? \_\_\_\_\_

Name & Phone of Attendee's... Primary doctor(s): \_\_\_\_\_ ...Dentist(s): \_\_\_\_\_

1. Please review and answer the questions below about the attendee's **allergies (circle 'Y' or 'N')**:

Y or N Is the attendee allergic to food? *Explain allergy and reaction:* \_\_\_\_\_

Y or N Does the attendee have any environmental allergies? *Explain allergy and reaction:* \_\_\_\_\_

Y or N Does the attendee have any other allergies? *Explain allergy and reaction:* \_\_\_\_\_

2. Please review and answer the questions below about the attendee's **dietary needs**. The Attendee... (circle Y or N)

Y or N ...eats a vegetarian diet. Y or N ...is gluten free. Y or N ...is dairy-free.

3. Please answer whether the attendee **currently or ever has experienced any of the following (circle 'Y' or 'N')**:

Y or N Ever had surgery?

Y or N Have recurrent or chronic illnesses?

Y or N Had a recent infectious disease?

Y or N Had a recent injury?

Y or N Had asthma or wheezing or shortness of breath?

Y or N Have diabetes?

Y or N Had seizures?

Y or N Had headaches?

Y or N Wear glasses, contacts, or protective eyewear?

Y or N Had fainting or dizziness?

Y or N Had mononucleosis ("mono") during the past 12 months?

Y or N Passed out or had chest pain during exercise?

Y or N If female, have problems with periods or menstruation?

Y or N Have problems with falling asleep or sleepwalking?

Y or N Ever had back or joint problems?

Y or N Have a history of bedwetting?

Y or N Have problems with diarrhea or constipation?

Y or N Have any skin problems?

Y or N Traveled outside the country in the last 9 months?

Y or N Has the attendee had chicken pox?

Y or N Has the attendee had a Tuberculosis (TB) test?

Comments & Explanations for responses above \_\_\_\_\_

4. Please answer the following questions and provide any explanations. The camp may contact you for additional information (circle Y or N)

Y or N Has the attendee ever been treated for attention deficit disorder (ADD) or attention-deficit/hyperactivity disorder (AD/HD)

Y or N Has the attendee ever been treated for emotional or behavior difficulties or an eating disorder?

Y or N During the past 12 months, has the attendee seen a professional to address mental or emotional health concerns?

Y or N Had a significant life event that continues to affect the camper's life? (*History of abuse, death of a loved one, adoption, new sibling, foster care, etc.*)

Comments & Explanations for responses above: \_\_\_\_\_

5. Is the attendee allergic to any medicine (circle Y or N)

Y or N If Y, Explain: \_\_\_\_\_

6. Please indicate if your attendee is **currently taking any medications or will be taking medications during the event**.

'Medication' is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Medicine will not be dispensed unless the following guidelines are met: - Prescription medications MUST have your attendee's name on the bottle

- Any doctor's office samples MUST be accompanied by a signed physician prescription
- Provide enough of each medication to last the entire time the attendee will be on location
- Our Health Center provides most common over the counter medications. Please do not send these to Camp Okoboji

**Medication #1:** Strength: Method (tablets, puffs, chewables, etc.):

# at Breakfast:	# at Lunch:	# at Supper:	# at Bedtime:	# As Needed
Special Instructions or Comments:				
<b>Medication #2:</b>		Strength:	Method (tablets, puffs, chewables, etc.):	
# at Breakfast:	# at Lunch:	# at Supper:	# at Bedtime:	# As Needed
Special Instructions or Comments:				

*List any additional medications on a separate sheet*

7. Please indicate dates of all **Attendee immunizations**. State law requires an accurate record of your attendee's current immunization status.

I have religious/personal objectives to vaccinations and this camper is in good health.

Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date
Diphtheria, Tetanus, Pertussis (DTaP or TdaP)		Mumps, measles, rubella (MMR)		Polio (IPV)	
Tetanus booster (dT or TdaP)		COVID-19		Other	

8. Answer the following and provide any explanations (circle Y or N)

Y or N I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

If N, Explain: \_\_\_\_\_

Y or N This attendee is covered by family medical/hospital insurance.

If Y – **please attach a copy of both the front and back of your health insurance card**

If N – **please attach a signed letter stating that you agree to pay for any medical costs in the event of an emergency.**

The following non-prescription medications may be stocked in the Health Center at Camp Okoboji and are used on an as needed basis to manage illness and injury.: Acetaminophen (Tylenol), Phenylephrine decongestant (Sudafed PE), Antihistamine/allergy medicine, Diphenhydramine antihistamine/allergy medicine (Benadryl), Sore throat spray, Lice shampoo or cream (Nix or Elimite), Calamine lotion, Laxatives for constipation (Ex-Lax), Ibuprofen (Advil, Motrin), Pseudoephedrine decongestant (Sudafed), Guaifenesin cough syrup (Robitussin), Dextromethorphan cough syrup (Robitussin DM), Generic cough drops, Antibiotic cream, Aloe, Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

**List any non-prescription medications that should NOT be given to the attendee:**

\_\_\_\_\_

9. Please provide in the space below any additional information about the attendee's health that you think is important or that may affect the camper's ability to fully participate in the camp program. What have we forgotten to ask?

\_\_\_\_\_

**10. Please read carefully and sign below to agree to the terms:**

This health history is correct and accurately reflects the health status of the attendee to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of this camper for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this camper. I understand the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of this camper's health record from providers who treat this camper and these providers may talk with the program's staff about this camper's health status.

I hereby give informed and expressed consent for this individual to take part in all camp activities under supervision, and agree that the camp or camp personnel will not be held responsible for accidents arising there from. I authorize the camp Health Care provider and/or designated camp staff to provide appropriate treatment to this individual for injuries and/or illness. This includes, but is not limited to, following Camp Okoboji's medical procedures and protocols, following poison control recommendations, administering prescription medications as noted above, administering over the counter medications as approved above, transportation to clinic or hospital care, and following directions from the medical director. I understand that the information on this form may be released to the appropriate medical personnel in case of emergency. I agree to pay any cost for medical care in the event of an emergency, even if I do not have health insurance coverage or not all costs are covered by insurance. I also understand that failure to disclose medical or emotional problems in advance may lead to serious consequences while at camp. Lastly, I verify that everything contained on this form is complete and accurate, to the best of my knowledge.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# JOY Camp Camper Information Form

## Camp Okoboji

The following information will be presented to all staff working with this camper. The information will be used only to serve the camper better. It will provide basic information concerning behavioral concerns and special considerations needed. This information will be considered confidential, not to be discussed in public or with people who are not serving this camper. We thank you for taking the time to provide us with this information. It will help make your camper have a positive experience while at camp.

Camper Name \_\_\_\_\_

Please give **Specific** information in the following areas that will assist the staff/helpers in assisting your camper. **This is very important if we are providing staff helpers for this program!**

1. Will a staff person be accompanying this camper?  Yes  No

If Yes please provide the following information:

Staff person's Name \_\_\_\_\_

Staff person's home phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Will the staff person be lodging at Camp Okoboji?  Yes  No

Will the staff person be having meals at Camp Okoboji?  Yes  No

2. What level of assistance does this camper need for the following items. Provide any additional information below:

Showering / Bathing	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Total	Provide any additional information here:
Getting Dressed	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Total	Provide any additional information here:
Eating	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Total	Provide any additional information here:
Oral Hygiene (i.e. brushing teeth)	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Total	Provide any additional information here:
Toileting (i.e. using the toilet; flushing)	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Total	Provide any additional information here:

3. Does the Camper need a wheelchair accessible room?  Yes  No

4. Provide any pertinent information about this camper's ambulation / mobility:

5. Provide any pertinent information about this camper's social behavior:

6. Provide any pertinent information about this camper's sleeping habits:

7. Provide any pertinent information about this camper's communication behaviors:

8. List any safety concerns about this camper's involvement in activities:

9. What hobbies / activities does this camper enjoy?

10. Provide any other information you feel our staff needs to know about this camper to provide the best JOY Camp Experience possible:

11. Roommate Preference: \_\_\_\_\_