

2013 Church of the Apostles Anglican Summer Programs Registration

*We recommend you **KEEP this COVER** sheet for your records.
(Six weeks from now we think you might be happy to have program dates and times handy!)*

- **COMPLETE ONE registration packet PER CHILD to register for all the programs for which you would like that child to attend.** Full instructions are on the back of this page. Complete a separate registration packet for each additional child. You may download copies from our website www.ChurchoftheApostles.org, or pick up copies in the Church Office.
- **When completing the registration forms, please refer to this page for the Dates, Ages, Costs, and ★Registration/Commitment Deadlines associated with each program listed below.** Detailed program descriptions can be found in our Summer Programs brochure and at our website.

VACATION BIBLE SCHOOL

When: 9:30am–12:00pm (July 18, July 25, Aug. 1)
Where: Ratcliffe Park (10300 Sager Ave., Fairfax, VA 22030)
Ages: 3–9 years old (Toilet-trained preschoolers, please)
Cost: Free (Donation accepted)
Snack: Will be provided
★ Registration Deadline: Monday, June 24, 2013


RESIDENT CAMP (Aug 4-9)

When: Sunday, Aug 4 (arrive at camp at 4:00pm) thru Friday, Aug 9 (depart from camp at 10:00am)
Parents are responsible for arranging transportation to and from camp for their child.
Where: Camp Highroad in Middleburg, VA
Age: Rising 4th–Rising 9th Grade
Cost: \$375.00 (\$25.00 deposit by 6/24/13*, Balance due July 30)
Scholarship funds are available. Contact Kristin Colligan for more information.

Family Meeting: Tuesday, July 30, 2013 at 7:00 pm, required for all Campers and a Parent;
Balance of fees is due at the family meeting.

...OVER...

Basic Instructions

- **COMPLETE ONE registration packet PER CHILD to register for all the programs for which you would like that child to attend.** Complete a separate registration packet for each additional child. You may download registration packets from our website www.ChurchoftheApostles.org, or pick up copies in the church office.
- Please provide **ALL** the information requested on each page, and **SIGN** the forms where indicated by .
- Make your check payable to COAA, memo: Children's Summer Program. **(Families may pay for multiple children with one check.)**
- Return or mail completed, signed forms, with payment to:

Church of the Apostles Anglican / Attn: Pam Marsh
10195 Main St. Suite T, Fairfax, VA 22031

About the General and Health Information Forms

- These forms are used for all children and students to age 18 who participate in programs sponsored by Church of the Apostles Anglican. We must have a completed, signed set of forms for each participating child in your family. Complete details and instructions are provided. If you have further questions, please contact the church office.
- General and Health Information Forms are considered VALID for 12 MONTHS from the date they are signed. Because we keep these forms on file for your family throughout the year, we ask that you provide us with any changes as soon as possible.
- *If you have filled out these forms for your child for any COAA program since Sept. 1, 2012*, and if the information you provided on those forms is still accurate, you DO NOT need to fill out new forms. However, prior to your child's participating in a program, you may be asked to sign a copy of the forms we have on file in order to confirm that the information they contain is accurate and up-to-date.
- We recommend you keep a dated photocopy of the forms for your personal records.
- If you are not sure if we have a current set of forms on file for your child, please call Pam Marsh at 703-591-1974, ext 102.
- A separate Photo Release Agreement is included on the last page.

Questions?

If you have any questions or need assistance with completing these forms,
please contact:

Kristin Colligan – Children's Ministry Director at 703-346-0289
KColligan@ChurchoftheApostles.org

OR

Pam Marsh – Children's Ministry Coordinator at 703-591-1974 (ext 102)
PMarsh@ChurchoftheApostles.org

Name of Child: _____

First

Last

Please register my child for the following program(s):

Refer to the front page for Dates, Ages, and deadlines for these programs.

VACATION BIBLE SCHOOL at Ratcliffe Park (10300 Sager Ave., Fairfax, VA 22030)

Free (Donations accepted)

Name of friend with whom you would like your child to be placed:

Every effort will be made to accommodate your request.

RESIDENT CAMP

\$375.00 OR Deposit of: \$25(*minimum deposit*)

T-Shirt Size: Youth: *S* *M* *L*

Adult *S* *M* *L* *XL*

Please refer to the front page of this packet for important information regarding deposits, deadlines, and a special pre-camp meeting required for Campers and Parents.

_____ Total amount due for this child

_____ Amount Paid

_____ Balance due



Signature

Date

Parent's/Guardian's Signature authorizing permission for child to participate in Church of the Apostles Anglican Summer Programs.

Office use only: Date rec'd _____ VBS _____ CAMP _____

Last Name: _____
Date: _____

General Information

This form is valid for 12 months and applies to all COAA programs for children and students up to age 18. To remain valid, any changes to the information included on this form must be provided to COA.

Name of Child: _____ Preferred Name: _____
First & Last

Birth Date: _____ Gender: M F Grade in September: ____
MM/DD/YYYY

Address of Child's Residence: _____
Street Apt / Unit

City: _____ State: _____ Zip: _____

Household Email: _____

Child lives with: Both Parents Mother Father Guardian

Parent / Guardian Information

Mother's Name: _____

Address (if different from children): _____
Street Apt / Unit

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Father's Name: _____

Address (if different from child's): _____
Street Apt / Unit

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Guardian's Name: _____

Home phone: _____ Work: _____ Cell: _____

Emergency Contact Information, in the event we cannot reach a Parent.

Name: _____ Relationship: _____

Home phone: _____ Work: _____ Cell: _____

Name of Child: _____

First

Last

Health Information

The following information must be completed by the Parent or Guardian.

Provide complete information so that the COAA staff can be aware of your child's needs. We recommend that you keep a dated copy of the completed form for your records.

Insurance

Is your child covered by family medical/hospital insurance? Yes No

Insurance company: _____ Policy or ID # _____

Name of physician: _____ Phone: _____

Name of dentist/orthodontist: _____ Phone: _____

Allergies: (List all known)

Medication allergies:

Describe reaction and management of the reaction.

- 1.
- 2.
- 3.

Food allergies:

Describe reaction and management of the reaction.

- 1.
- 2.
- 3.

Other allergies:

Describe reaction and management of the reaction.

- 1.
- 2.
- 3.

Asthma Inhalers and Epi-Pens

Please provide detailed instructions on asthma treatment protocol and use of Epi-Pens.

First Name: _____

Last Name: _____

Current Medications

1. Please list all medication taken regularly (including over-the-counter or non-prescription drugs), **even if a regular dose is not scheduled during the program for which your child is registered.** In the unlikely event of an emergency, we need to be able to provide this information to emergency medical personnel as part of your child's health history.
2. **If your child will need to take medication during the program,** please be sure to send enough medication with your child to last throughout the program. Keep it in the original packaging/bottle that identifies the child, prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. **Attach additional pages as needed for more medications.**

This child takes **NO** medication on a routine basis.

Identify any medications taken during school year that your child does not /may not take during the summer.

This child currently takes medication as follows:

Med #1: _____ Dosage: _____

Specific times taken each day _____ Reason needed _____

Med #2: _____ Dosage: _____

Specific times taken each day: _____ Reason needed: _____

Med #3: _____ Dosage: _____

Specific times taken each day: _____ Reason needed: _____

Over-the-Counter Medications

Initial all over-the-counter medications you allow and then choose [A]dult or [C]hild for dosage when applicable.

(Initial) (A or C)

_____ Acetaminophen (Tylenol)*
 _____ Betadine Solution
 _____ Antihistamine*
 _____ Dramamine /Bonine
 _____ Decongestant*
 _____ Hydrocortisone Ointment
 _____ Ibuprofen (Advil/Motrin)*

Initials (A or C)

_____ Ibuprofen (Advil/Motrin)*
 _____ Hydrogen Peroxide
 _____ Naproxen (Aleve)*
 _____ Swimmer's Ear Drops
 _____ Sting Stop for bites
 _____ Antacids

Health History for: Name: _____

Do any of the following items apply to your child?

Yes or No

Recent injury, illness, or infectious disease?	.
A chronic or recurring illness/condition?	.
Ever been hospitalized?	.
Have frequent headaches?	.
Ever been knocked unconscious?	
Wear glasses, contacts, or protective eye wear?	
Ever had frequent ear infections?	
Ever passed out during or after exercise?	
Ever been dizzy during or after exercise?	
Ever experience motion/car sickness	
Ever had seizures?	
Ever had chest pain during or after exercise?	
Ever had high blood pressure?	
Ever been diagnosed with a heart murmur?	
Ever had back problems?	
Ever had problems with joints (knees, ankles)?	.
Have an orthodontic appliance?	.
Have any skin problems (itching, rash, acne)	
Have diabetes?	
Have asthma?	
Had mononucleosis in the past 12 months?	
Had problems with diarrhea/constipation?	
Have problems with sleepwalking?	
If female, have an abnormal menstrual history?	
Have a history of bed-wetting?	
Ever had an eating disorder?	
Ever had emotional difficulties for which professional help was sought?	

Please explain any "Yes" answers: _____

Name: _____

Immunizations: *Are your child's immunizations up to date?* Yes No
Date of last Tetanus Shot: _____

Date of last PPD or TB skin test: _____ Result: Positive Negative

Physical Limitations

Describe any restrictions to activity (e.g., what cannot be done, what adaptations or modification are necessary.)

Other Helpful Information

Please provide any additional information about your child's physical, emotional, or mental health, or social development that will help us do all we can to help your child have a positive experience with us. If there is anything you would like to discuss, please contact Kristin Colligan at 703-346-0289

Dietary Restrictions: *Not allergies!*

This section does NOT apply to food allergies. Instead, this section applies only to family preferences or customs. Every effort will be made to accommodate requests for dietary restrictions. If your child has an adverse health reaction to any type of food, please list it in the Allergies section of this form.

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat seafood / shellfish | <input type="checkbox"/> Does not eat poultry |
| <input type="checkbox"/> Does not eat eggs | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat dairy products |

Health Release Form

The information provided in this document is accurate to the best of my knowledge. On behalf of my child _____, I give permission to Church of the Apostles Anglican (COAA) to provide routine health care, administer prescribed medication, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to COAA to arrange necessary related emergency transportation for the person named. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by COAA to secure and administer treatment, including hospitalization, for the person named.

In addition, I give COAA staff and volunteers permission to pray with and for my child (named above).



Parent's / Guardian's Signature

Date

PRINT Parent/Guardian Name: _____

A photocopy of the FRONT and BACK of your child's Health insurance card MUST be attached to this form.

Photo Release Agreement

Regarding permission for Church of the Apostles Anglican to use only for promotional purposes any photos or video material of my child:

First Name

Last Name

taken while he/she is a participant in any programs, activities, events, or worship services affiliated with Church of the Apostles Anglican, its Children's Ministry and/or its Student Ministries:

I understand that the photos or video images may be used in print material, on the church's website at www.ChurchoftheApostles.org, in the e-letter *Apostles News* or on the church's Facebook page.

I also understand that my child's name will NEVER, **EVER** be included with any image that may be used by the church for any reason.

I further reserve my right to withdraw this permission at any time.



YES, I grant permission.

Parent's/Guardian's Signature

Date

PRINT Parent/Guardian Name: _____



NO, I do NOT grant permission.

Parent's/Guardian's Signature

Date

PRINT Parent/Guardian Name: _____