

Membership Status Renewing New
Program: Club Program

Camp Fire USA Northwest Ohio Council: Youth Registration

305 W. Hardin St. Findlay, OH 419-422-5415

Club Name (to be completed by office): _____

Child's Name:

_____ Last First Initial
Home Address:

_____ Street Address City State Zip County

Child's Email (if applicable): _____

Gender: _____ Birth Date: _____ Age: _____ Does this child have an IEP? _____

School: _____ District: _____ Grade: _____

Custodial Parent/Guardian:

_____ Last First Relationship
Home Address:

(if different than above) _____ Street Address City State Zip County

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Email: _____

Second Parent:

Name: _____ Relation: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact (in case parents cannot be contacted):

Name: _____ Relation: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Email: _____

Please complete additional information on Page 2

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**Camp Fire USA Club annual registration fee is \$20 (includes t-shirt)**

**Payment Method:** \_\_\_Dish Cloth Money \_\_\_Check \_\_\_Cash \_\_\_Credit Card (verbally provide to office)

**T-shirt Size** \_\_\_\_\_ (Youth S-L or Adult S-3XL)

**Additional t-shirts for club kid or family members are available for \$10. Rec. #** \_\_\_\_\_ **Date** \_\_\_\_\_

**Demographics: Information which greatly assists our funding (optional)**

|                                           |                                            |                                                  |                            |
|-------------------------------------------|--------------------------------------------|--------------------------------------------------|----------------------------|
| Ethnic/Racial:                            | Household Income:                          | Household Structure:                             | Primary Language: _____    |
| <input type="checkbox"/> African American | <input type="checkbox"/> under \$15,000    | <input type="checkbox"/> 2 Parent Household      | Number in Household: _____ |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> \$15,001-\$25,000 | <input type="checkbox"/> Foster Parents          | Parent 1: Employer: _____  |
| <input type="checkbox"/> Caucasian        | <input type="checkbox"/> \$25,001-\$35,000 | <input type="checkbox"/> Guardianship            | Occupation: _____          |
| <input type="checkbox"/> Hispanic         | <input type="checkbox"/> \$35,001-\$45,000 | <input type="checkbox"/> Single Parent Household | Parent 2: Employer: _____  |
| <input type="checkbox"/> Multi            | <input type="checkbox"/> \$45,001-\$55,000 | <input type="checkbox"/> Other                   | Occupation: _____          |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> over \$55,000     |                                                  |                            |
| <input type="checkbox"/> Other            |                                            |                                                  |                            |

**Medical Information:**

Health Insurance Carrier\*: \_\_\_\_\_ Policy No. \_\_\_\_\_  
 Primary Care Physician\*: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Primary Dentist\*: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\*For those without Health Insurance: In understand and agree to absolve all the staff, organizers, and associated entities, singly and collectively, of all blame for injury, harm, mis-adventure or loss suffered as a result of taking part in any of the official activities of Camp Fire USA NW Ohio. As an uninsured party, I also consent to permit emergency medical treatment in case of injury or illness and will be responsible for all expenses for treatment received.

|                               |                           |      |
|-------------------------------|---------------------------|------|
| Print Name of Parent/Guardian | Parent/Guardian Signature | Date |
|-------------------------------|---------------------------|------|

**Allergies:** List all known (medications, insect stings, hay fever, animal dander, etc) and describe reaction and management of reaction.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN:** Please list all prescription medication taken routinely. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and frequency of administration.

- This child takes NO Medications on a routine basis
- This child takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_  
 Specific times taken each day \_\_\_\_\_  
 Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_  
 Specific times taken each day \_\_\_\_\_  
 Reason for taking \_\_\_\_\_

Has this child had a tetanus shot in the last 5 years? \_\_\_\_\_ If yes, date: \_\_\_\_\_

Does this child have any medical conditions that we should be aware of? (asthma, diabetes?) Explain

\_\_\_\_\_  
\_\_\_\_\_  
Any additional information we should know? \_\_\_\_\_  
\_\_\_\_\_

"In consideration of the opportunity to participate in programs of Camp Fire USA, I hereby assume all risks and release and hold harmless the council and all it's members, volunteers, and employees from any claims which might arise as a result of my presence, participation or membership in the association"

- I give permission for my child to be transported for the purpose of field trips. I release (organization) and individuals from liability in case of accident during activities related to (organization), as long as normal safety procedures have been taken.**
- I give permission to Camp Fire USA for the unrestricted use of my child's name, photograph or other likenesses of his/her property for advertising trade or similar purposes. I give this consent voluntarily without any expectation of remuneration or reward and I do hereby waive my right to such reward.
- I understand in the event of any accident or emergency that every effort will be made to contact me. However, in the event that I cannot be reached, I hereby give my permission to the physician selected to give proper treatment, administer injections and to perform surgery as needed if necessary.

|                           |      |
|---------------------------|------|
| Parent/Guardian Signature | Date |
|---------------------------|------|