

For Office Use Only

Date Rec. _____

Reg. Fee Pd. _____

1st Wk. Fee Pd. _____



6657 Kimesville Road, Liberty, NC 27298

336-565-9723~~Fax 336-565-0644~~www.KopperTop.org

CAMP FREESPIRIT 2012
SUMMER CAMP REGISTRATION

Registration Fee: **\$25.00** - reservation (*Non-refundable*)

Weekly Fee: **\$175.00** per camper per week

Total= \$200.00 per camper for first week

Please make checks payable to: **Kopper Top Life Learning Center**

Camper's Name _____ Date of Birth _____

Address _____ Sex: M F (circle one)

City/State _____ Zip Code _____

Phone: (H) _____ (W) _____ Email: _____

FAMILY INFORMATION

Mother/Guardian: _____ Home phone: _____

Employer: _____ Work phone: _____

Address: _____ City/State: _____

Father/Guardian: _____ Home phone: _____

Employer: _____ Work phone: _____

Address: _____ City/State: _____

Emergency Contacts: 1. _____ Phone: _____

2. _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Medical Center: _____ City: _____

Insurance Carrier: _____ Policy#: _____

Allergies: _____ Medication/s: _____

Information about my daughter/son/ward that may assist staff in any way (medical assistance, characteristics, behaviors): _____

Kopper Top Life Learning Center PERMISSION & LIABILITY RELEASE

Yes, I would like _____ (Camper's name) to participate in the Kopper Top Life Learning Center, Inc. Summer Camp Program (**Camp FreeSpirit**). I understand **that NO LIABILITY** can be accepted or assigned by any organization or individual concerned with this care, including Kopper Top Life Learning Center, Inc. and the Summer Camp Program in the event of any accident, which may occur. I acknowledge the risks and potential for risks. I hereby, intending to be legally bound, for myself, my heirs and assign, executors or administrators, waive and release forever all claims for damages against Kopper Top Life Learning Center, Inc., its Board of Directors, Instructors, Volunteers and/or staff for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in the Kopper Top Life Learning Center, Inc. Summer Camp Program. **I further give permission for my child to be transported to any special outing.**

I DO DO NOT (Circle one!) give the staff/volunteers of Kopper Top Life Learning Center, Inc. permission to transport my camper via staff vehicle or Emergency Medical Services to Medical Center stated above, if I am unable to be reached in case of emergency.

I do do not (circle one) consent to and authorize the use and reproduction by Kopper Top Life Learning Center, Inc. and it's partner program, Elon University and students, of any and all photographs and any other audio/visual materials taken of me/my participant, for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Warning:

"Under North Carolina law, an equine activity sponsor or equine professional is not liable for an injury to or death of a participant in equine activities resulting exclusively from inherent risk of equine activities. Chapter 99 E of the North Carolina General Statute."

"Under North Carolina law, there is no liability for an injury to or death of a participant in an agritourism activity conducted at this agritourism location if such injury or death results from inherent risks of the agritourism activity. Inherent risks of agritourism include, among others, risks of injury inherent to land, equipment, and animals, as well as the potential for you to act in a negligent manner that may contribute to your injury or death. You are assuming the risk of participating in this agritourism activity."

Signature of Parent(s)/Legal Guardian: _____ Date: _____

Other individuals permitted to pick up my camper, with picture identification. No camper will leave the premises without a parent/guardian signature.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I would like to register my camper the week/s of (check all that apply):
Camp programs begin at 9:00 a.m. You may drop off as early as 8:00 a.m. Pick up no later than 1:00 p.m.

- | | |
|------------------------|------------------------|
| _____ June 11-15 | Outdoor/Horseback Camp |
| _____ June 18-22 | Outdoor/Horseback Camp |
| _____ June 25-29 | Outdoor/Horseback Camp |
| _____ July 9-13 | Outdoor/Horseback Camp |
| _____ July 16-20 | Outdoor/Horseback Camp |
| _____ July 23-27 | Outdoor/Horseback Camp |
| _____ July 30-August 3 | Outdoor/Horseback Camp |
| _____ August 6-10 | Outdoor/Horseback Camp |

You may register for more than one week and you may register for any week that you wish. We will accommodate individuals with disabilities at any time.

**For further information, questions, concerns,
please call 336-565-9723 or check out our website at: www.KopperTop.org
Kopper Top Life Learning Center, Inc.
6657 Kimesville Road
Liberty, North Carolina 27298**

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height _____ Weight _____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____
 Medications: _____
 Seizure Type: _____ Controlled Y N Date of Last Seizure _____
 Shunt Present: Y N Date of last revision: _____
 Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Special Need	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg. PT, OT, SLP, Psychologist, etc.) in the implementation or an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____
 Signature _____ Date _____
 Address: _____
 Phone:() _____ License/UPIN Number _____



**AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM
Camp FreeSpirit 2012 Participant**

Name: _____ DOB: _____ Phone: _____

Address: _____ City/State/Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medication: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize Kopper Top Life Learning Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____

Participant, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place.

Date: _____ Consent Signature: _____

Participant, Parent or Legal Guardian
Signed in the presence of center staff

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY MUST BE ATTACHED TO THIS FORM