



The Salvation Army  
**HIDDEN FALLS CAMP & CONFERENCE CENTER**  
 208 Hidden Falls Camp Road, Bedford, Indiana 47421  
 (812) 279-2495

**YOUTH CAMP**  
**CAMPER APPLICATION – SUMMER 2016**  
*(Complete all information & signatures)*

Corps: \_\_\_\_\_

Please submit with camper fee (\$25 per session) or scholarship application attached.

**1. Check camp sessions camper will attend:**

Sports Camp (Ages 9-17) June 13-17	Mini-Mites Camp (ages 6-8) July 12-15 (Tues-Fri)
Character Building Camp (Ages 6-17) June 27- July 1	Music Camp (ages 9-17) July 18-23 Junior Music Camp (ages 7-8) July 18-23
Junior Camp (Ages 9-12) July 5-9 (Tues-Sat)	Teen Camp (ages 13-17) July 25-29

**2. Camper Information** *(Please print)*

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>SEX: (CIRCLE) M F</b>	
<b>Address:</b>		<b>Birthdate:</b>		<b>Age:</b>	
<b>City:</b>		<b>Grade Completed:</b>			
<b>State:</b>	<b>Zip:</b>	<b>Corps/Church:</b>			
<b>Camp T-Shirt Size: (please circle)</b>		<b>Youth: S M L</b>		<b>Adult: S M L XL XXL 2XL 3XL</b>	
<b>Parent or Guardian Last Name:</b>			<b>First Name:</b>		
<b>Address:</b>			<b>Email:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>Phone: ( )</b>		

**3. Emergency Information** *(Please print)* If parent/guardian cannot be reached in the event of an emergency

<b>1. Name:</b>	<b>1. Name:</b>
<b>2. Relationship:</b>	<b>2. Relationship:</b>
<b>3. Home Phone:</b>	<b>3. Home Phone:</b>
<b>4. Cell Phone:</b>	<b>4. Cell Phone:</b>

**4. Over The Counter Medicines and First Aid Treatment**

**Check those which CAN BE applied and/or administered to this camper while at Hidden Falls Camp:**

<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Diphenhydramine HCL (Benadryl)	<input type="checkbox"/> Antacid
<input type="checkbox"/> Hydrocortisone Cream	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Antibiotic Ointment	<input type="checkbox"/> Insect Repellent	<input type="checkbox"/> Band Aids
<input type="checkbox"/> Loperamide (Imodium)	<input type="checkbox"/> Calamine Lotion	<input type="checkbox"/> Sunscreen
<input type="checkbox"/> Cough Suppressant	<input type="checkbox"/> Topical Analgesic	<input type="checkbox"/> Decongestant

**5. Household**

Does camper have siblings or other family members who will also attend Hidden Falls Camp for Summer 2016? List names and relationship:

\_\_\_\_\_

\_\_\_\_\_

# CAMPER HEALTH AND MEDICAL HISTORY

This side to be filled out by parent/guardian or adult camper (18 & over)

Camper Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

## MEDICATIONS INFORMATION

Any camper who needs medication dispensed at camp **MUST** have this section completed. **ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH PRESCRIPTION LABEL AFFIXED.**

	Name of Medication	Time/Dosage Given	Reason for Medication
1			
2			
3			
4			
5			

## HEALTH HISTORY

(Check. Give approx. dates:

- \_\_\_\_\_ Tetanus Shot
- \_\_\_\_\_ Frequent ear infections
- \_\_\_\_\_ Heart defect/disease
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Bleeding/clotting disorder
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Mononucleosis
- \_\_\_\_\_ Psychiatric treatment
- \_\_\_\_\_ Strep throat

### Diseases:

- \_\_\_\_\_ Chicken Pox
- \_\_\_\_\_ Measles
- \_\_\_\_\_ German Measles
- \_\_\_\_\_ Mumps
- \_\_\_\_\_ Lead poisoning
- \_\_\_\_\_ Sickle Cell

### Allergies: (Dates not needed)

- \_\_\_\_\_ Hay Fever
- \_\_\_\_\_ Poison Ivy, Poison Oak
- \_\_\_\_\_ Insect Stings
- \_\_\_\_\_ Penicillin
- \_\_\_\_\_ Other drugs \_\_\_\_\_
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

Does your child have any behavior considerations that might cause concern while at camp? \_\_\_\_\_ Explain: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Dietary Restrictions:** \_\_\_\_\_

Operations or serious injuries (dates): \_\_\_\_\_

Activities to be limited: \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry family medical/hospital insurance? Yes  No

**If YES, indicate:** Name of Insured: \_\_\_\_\_

Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Medical Assistance # \_\_\_\_\_

**Additional Health Information:** \_\_\_\_\_

### FOR FEMALE:

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special considerations: \_\_\_\_\_

## IMPORTANT

**This section MUST be completed for attendance at camp**

By my signature below, I am stating that this health history is correct to my knowledge, and the person herein described has permission to participate in all camp activities unless stated in writing by physician. I hereby give permission to the medical personnel selected by a representative of The Salvation Army to order X-rays, routine tests, treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by a Salvation Army representative to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper: \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

## POLICIES & AGREEMENT

### Parent Contact

Camp Leadership will call the parent/guardian, identified on this form; any time health care outside of camp is necessary for your child. In an emergency, should the parent/guardian not be available by phone, we will call the alternate contacts. Emergency care will not be withheld in the event the parent/guardian or alternate contact is not available by phone. Campers will not have regular access to a phone to contact their parents, but messages can be left at the office to be given to campers.

### Head Lice

Your child will be checked for head lice upon arrival at camp. If lice or nits are found, your child will be sent home. Your child will not be able to return to the current camp. Please take the appropriate measures to ensure this unfortunate outcome won't affect your child's camp experience. This policy is non-negotiable and is for the protection of all campers. Please see the Head Lice Policy in the attached camp information packet for treatment procedures to ensure that your child can attend future camps.

### Dress Code

The camper is expected to abide by the dress code as outlined in the attached camp information packet. If camp leadership indicates that the camper's clothing breaks the dress code, the camper must change his/her clothing before being allowed to resume camp activities. If the camper refuses to change, this may result in parent contact and possible dismissal from camp.

### Medications

All medications (including over the counter or nonprescription medication) **must** be turned in to the Camp Health Officer. They must be in the original container (or accompanied by doctor's note) that identifies the prescribing physician, the name of the medication, dosage, and the frequency of administration. Over the counter medication will only be administered on a regular basis if accompanied by a note from a physician indicating the above information. Bring enough medication to last the duration of the camp. *Please Note: If your child needs medication when attending school, then that medication is also needed at camp.*

### Parent Agreement (MUST BE COMPLETED FOR ATTENDANCE)

I wish to enroll \_\_\_\_\_ in the above camp sessions. In signing this application I understand that my child will be expected to abide by the rules of the camp and the guidance of his/her leaders. I will help my child understand the importance of getting along with other campers and obeying the camp leaders.

I agree that my child shall participate in the entire camp program set up by The Salvation Army which includes religious services. I understand that if my child does not adhere to the camp policies and/or has severe misconduct, he/she may be sent home and that it is my responsibility to provide transportation home from Hidden Falls Camp.

By signing below, I also understand and give permission for my child to ride in a Salvation Army vehicle for transportation to and from Hidden Falls Camp, while on camp for special circumstances including field trips. I hereby give my permission for my child to participate in off-camp activities should these be included in the schedule.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### CAMPER CODE OF CONDUCT

I \_\_\_\_\_ agree to conduct myself in a manner that will be a credit to me, to Hidden Falls Camp, to The Salvation Army, to all involved in the summer camp session, and to my church/corps community. I will:

1. Dress appropriately and wear whatever clothing and/or equipment required for activities.
2. Show respect for the rights, privacy and property of others.
3. Show respect for the property and facilities of Hidden Falls Camp and The Salvation Army.
4. Comply with the schedule for programs, activities, meal times and limitations on free time activities.
5. Not possess or use any alcohol, tobacco or drugs during camp.
6. Not bring to camp flammable or explosive materials, poisons, weapons or pets.
7. Take responsibility for my own personal property.
8. Agree to abide by all local, state and federal laws and rules and regulations issued by Hidden Falls Camp staff and The Salvation Army or their representatives.
9. Cooperate with and show respect to the camp staff, other participants, representatives of Hidden Falls Camp, The Salvation Army, and invited guests.
10. Not use profanity while at Hidden Falls Camp.
11. Follow guidelines for public displays of affection.
12. Attend and be reverent in all worship services at Hidden Falls Camp.

### Camper Agreement (MUST BE COMPLETED FOR ATTENDANCE)

By signing, I promise to be a good camper at Hidden Falls Camp. I will obey the rules, policies and camper code of conduct. I will respect all other campers and leaders. I understand that if I break the rules or show disrespect for others, I may be sent home. I sign this on my honor.

Camper Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**The Salvation Army Hidden Falls Camp  
Challenge Course, Paintball, Archery, Rifles and Bikes  
Participant Assumption of Risk and Waiver Agreement**

\_\_\_\_\_  
Print Participant Name

**Salvation Army Summer Camps**  
\_\_\_\_\_  
Print Name of Group

\_\_\_\_\_  
Parent/Guardian Name if under 18 years of age

\_\_\_\_\_  
Date

**Instructions: Please read this form carefully. Each participant and his/her parent/guardian must initial each paragraph and sign at the bottom. Without all the appropriate signatures, the individual will not be permitted to participate in the programs.**

The challenge course program involves a variety of activities including warm-ups, games, group initiatives, low and high course elements, and possibly other rigorous physical adventure activities. The paintball, archery, and riflery programs involve a variety of activities, including target practice and team competitions. The bike program involves a variety of activities including both trail and pavement riding.

I understand that I will be participating in activities that involve periods of physical exertion, balancing, heights, lifting, pushing, pulling, climbing, cycling, shooting, marking, exposure to paintball pellets. I know most activities will be outdoors where I will need to watch for slippery and/or uneven footing, limbs and branches, insects or animals, and possible exposure to extreme or inclement weather.

I understand that there is risk of bodily and/or psychological injury, including a potential for permanent disability or death, resulting from any participation in the programs and/or from the equipment involved in my participation. I understand that the risks also include loss or damage to personal property. I freely assume all such risks, both known and unknown, and assume full responsibility for my participation. I understand that I will be thoroughly informed of the rules of participation, including all safety related rules, and agree to fully comply with them during my participation.

I understand that all possible precautions are taken to insure that all programs and activities sponsored by The Salvation Army Hidden Falls Camp and Conference Center are conducted by mature, qualified, and certified personnel in a safe and responsible manner.

I understand that my participation in challenge course, paintball, archery, bikes, and riflery programs offered by Hidden Falls Camp and Conference center is based on the Participation is Voluntary philosophy. At all times I will choose my level of participation in any activity. I agree to exercise good personal judgment, to ask for help if concerned about my safety, and to be responsible for deciding if a proposed activity is appropriate for me.

I have informed the camp on the appropriate medical form of any physical, mental, or medical condition that might affect my ability to participate or affect other members in my group. I realize that failure to provide such information could result in serious harm to me, my child, or others. I also state that I am not under the influence of any chemical substance, including alcohol.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin hereby release and hold harmless The Salvation Army, an Illinois Corporation, its officers, employees, agents, and associates and The Salvation Army Hidden Falls Camp and Conference Center, its employees, agents, and associates, harmless for accidents, injury, death, loss or damage to property that might occur during these programs.

By signing this waiver I indicate that I have read and understand all materials outlining the challenge course, paintball, archery, bikes, and riflery programs participation for myself, including this waiver and agree to abide by these terms. I am aware that this is a waiver and a release of liability, and I sign it voluntarily.

**If I am completing this form for my minor aged child, I give permission for him/her to participate in these activities.**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Parent/Guardian if under 18 years of age

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip



# The Salvation Army Photo Release Form

**PURPOSE:**

To obtain from photo and interview subjects the right to use their portraits and statements in Salvation Army publications, promotions, and/or advertising. Those under the age of 18 must have a parent or legal guardian to sign for them.

**LEGAL:**

I hereby irrevocably grant to The Salvation Army the absolute right and permission to copyright and/or publish or use photographic portraits of me (or my child), or in which I (or my child) may be included in whole or in part, or composite or distorted in character form, in conjunction with my (or my child's) name or a fictitious name, or reproductions thereof in color or otherwise, made through any media, including social, for art, advertising or any other lawful purpose whatsoever. I also grant The Salvation Army the same right and permission to use any statements or testimonials made by me (or my child).

DATE: \_\_\_\_\_

CAMPER NAME: \_\_\_\_\_

ADDRESS:  
\_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT /GUARDIAN NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

-----  
OPT OUT: I do **NOT** give permission to The Salvation Army to use my (or my child's) photograph or statements in any publication.

CAMPER NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT OR GUARDIAN NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

# Household Application for the Summer Food Service Program

(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to:

The Salvation Army

If you need help, call **812-279-2495**

**Follow these instructions, if your household gets SNAP TANF or FDPIR:**

**Part 1:** List participant's name and a SNAP, TANF or FDPIR case number.

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Sign the form. A Social Security Number is NOT required.

**Part 5:** Answer this question if you choose to.

**If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:**

**Part 1:** Enter the child's name.

**Part 2:** Please contact us at **812-279-2495**

**Part 3:** Complete this part if you are applying for other children in the household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.

**Part 4:** Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.

**Part 5:** Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List each participant's name.

**Part 2:** Skip this part.

**Part 3:** Follow these instructions to report total household income from last month.

**Column A–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B–Gross income last month and how often it was received.** Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

**Column C–Check if no income:** If the person does not have any income, check the box.

**Part 4:** An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

**Part 5:** Answer this question if you choose to.

**Privacy Act Statement:** This explains how we will use the information you give us.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.

<b>Part 1. Children enrolled in Camp or Closed Enrolled Sites.</b>					
Names (First, Middle Initial, Last)			SNAP, TANF or FDPIR case # (if any). <b>Skip to Part 4 if you listed a case #.</b>		
<b>Part 2. Foster Child</b>					
Foster children are eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact [name of Sponsor] at [phone number]. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.					
<b>Part 3. Total Household Gross Income—You must tell us how much and how often</b>					
<b>A. Name</b> (List <b>everyone</b> in household, including children) <i>(Example)</i> <i>Jane Smith</i>	<b>B. Gross income and how often it was received</b> <i>Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly</i>				<b>C. Check if NO income</b>
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
	\$200/weekly	\$150/weekly	\$100/monthly	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
<b>Part 4. Signature and Social Security Number (Adult must sign)</b>					
An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)					
<i>I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.</i>					
Sign here: X _____ Print name: _____ Date: _____					
Address: _____ Phone Number: _____					
Last four digits of Social Security Number: _____ <input type="checkbox"/> I do not have a Social Security Number					
<b>Part 5. Participant's ethnic and racial identities (optional)</b>					
Mark one ethnic identity:		Mark one or more racial identities:			
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Asian			
<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> American Indian or Alaska Native			
		<input type="checkbox"/> White			
		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
		<input type="checkbox"/> Black or African American			
<b>Don't fill out this part. This is for official use only.</b>					
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12					
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year					
Household size: _____					
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___					
Reason: _____					
Determining Official's Signature: _____				Date: _____	
Confirming Official's Signature: _____				Date: _____	
Follow-up Official's Signature: _____				Date: _____	

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.