

Hello Mount Hermon Conferee & Your Parent/Guardian!

We're so excited that you are planning on joining us this summer at our Mount Hermon Summer Conference. We know God is going to do some amazing things that week and we hope that if you are able to join us. And we hope that during that time He would teach you amazing things through His Word and through your time with your fellow conferees and our staff.

For those of you who have attended Mount Hermon in the past you probably noticed that the registration form looks different this year. Recently the state of California has instituted new regulations for summer camps and one of our new rules is a more comprehensive Health History form. **Starting this year, the form is now part of the registration material that must be turned in before you are officially registered for camp.** Please make sure to fill out the registration form completely before sending it in with your full payment. Any incomplete forms will be sent back to you and you will not be registered & confirmed until a complete form is turned in. This could cause you to be waitlisted for camp.

If a Health History form is not available at your church, they can be downloaded on our website. www.JEMS.org/registration

If you have any further questions about our Mount Hermon Youth Camp programs please feel free to contact me at LillyToke@JEMS.org or (213) 613-0022

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LILLY Tokuyama

JEMS Youth & Young Adult Ministries Director

-JUNIOR HIGH CAMP-
61st Annual JEMS MOUNT HERMON SUMMER CONFERENCE June 27 – July 3, 2010
 Registration Deadline May 1, 2010 After May 1st add \$25

FOR OFFICE USE ONLY

Name _____ F M
Last Name First Name

Address _____
Street City State Zip

() _____ Parent's E-Mail _____
Home Phone Please PRINT clearly

Birthdate _____ Grade in Fall '10 _____ First Timer? Y N
Age Month Day Year

Church _____ Room with _____
Name City (First Timers only, no guarantees)

Please Send:

Bus Registration (SoCal only) Map to Campground

Acceptance into camp is on a first-come basis.

Please read and complete all information below. Thank You!

<input type="checkbox"/> Camp Fee	\$405
<input type="checkbox"/> Camp Photo	\$ 9
<input type="checkbox"/> Late Fee (after May 1 st)	\$ 25
Total Enclosed	\$
<i>Please make checks payable to JEMS</i>	

Amt \$
 Check #
 Amt. Due \$
 Confirm date:
 Confirmation sent Y N
 Cabin:
 Waiting list date:
 ROLL CALL
 PRESENT
 Arrive date:
 First meal:
 Last meal:
 Depart date:
 NO SHOW
 Cancel date:
 Refund Amt \$
 Date refund sent:
 Refund check #
 Check to:

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NOTE NEW REGISTRATION PROCEDURES
PLEASE READ CAREFULLY

The Mount Hermon Youth Summer Conference is a week-long activity and requires that all conferees attend the camp in its entirety. Please make sure to schedule your (or your child's) school & other activities so it does not conflict with our summer camp program. Please initial here that you agree and understand our policy on no part-time conferees. _____

The state of California has issued new regulations in regards to information that needs to be collected for all Mount Hermon conferees. Please fully complete and sign a Mount Hermon Health History form and submit it with your (or your child's) Mount Hermon registration form. Registration will not be accepted until the health history form is received and is complete. Please initial here that you understand this health history form requirement. _____

PARENT/GUARDIAN PERMISSION: (Required for conferees under 18 years of age & all special campers) As the parent/guardian of camper, I hereby grant permission for attendance and authorize JEMS camp staff to make any necessary decisions in case of unruly conduct and/or medical emergency. I will be responsible for any expenses incurred, including medical & transportation costs. I also voluntarily release & discharge & will indemnify, defend and hold harmless JEMS, its directors, officers, employees, or agents (collectively "JEMS Parties") from any injury or damage to said person or property due to negligence, carelessness, or any other cause.

Signed _____ Date _____

CAMPERS COMMITMENT: I agree to abide by camp regulations and participate in the entire program. I understand that this is a camp with Christian standards and that the camp administration/JEMS staff reserves the right to dismiss anyone who does not comply. Expenses for this will be charged to me, my parents or guardian.

Signed _____ Date _____

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VALID & COMPLETE registration must be accompanied with FULL PAYMENT, signed and mailed to JEMS MOUNT HERMON SUMMER CONFERENCE 948 E. Second St. Los Angeles, CA 90012. Incomplete forms will be returned without processing.

DEADLINE: postmarked no later than May 1, 2010. After deadline, add \$25 per person. All camps start on Sunday with registration between 2 – 5pm. Conference ends Saturday around 12 noon. Please notify us if you plan on arriving AFTER 5pm on Sunday June 27th.

ACCEPTANCE INTO CAMP is on a first-come basis, no exceptions. Notification of confirmation is receipt of guaranteed accommodations. Please remember that we are not responsible for the condition of your accommodations or the conference grounds.

REFUNDS/CANCELLATIONS: All cancellations are subject to a non-refundable processing fee of \$25/person up to Friday, May 14, 2010 at 5:00pm. After which the fee increases to \$50 per person. (Notification of cancellation must be made directly to the JEMS office by letter, fax or e-mail **by Mon. June 21st, 5:00pm after that date no refund will be given.**)

TRANSPORTATION: Bus rides to camps from Southern California and return are available. Limited shuttle pick up from San Jose Airport to Mount Hermon is available between 1:30 & 4:00pm on June 27th with a possible nominal fee. Pick up arrangements must be made through the JEMS office by 6/1/10 with complete flight information.

HEALTH HISTORY FORMS: can be downloaded on our website www.JEMS.org/registration

2010 JEMS Mount Hermon Youth & Special Camp Health History Form

Full Name _____ Date of Birth _____ Age at Camp _____

Home Address _____ Gender Male Female

City _____ State _____ Zip _____

The information provided on this form will be used to brief our staff about your nutritional needs and to educate our directors & health supervisor about your health background and needs. Receiving adequate information is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly, any incomplete forms will be returned to you and you will not be registered for camp until a completed form is received. **If you are under 18, please have your parents complete this form and sign the consent and authorization for health care on the back of this form.**

HEALTH HISTORY: Please keep a copy for your records and record changes to your health status. Please notify JEMS in writing if there are any changes before you arrive at camp. **Please feel free to add additional information on separate sheets of paper.**

ALLERGIES: Please mark those that apply

I have no known allergies

I am allergic to the following food(s): _____
Does this cause anaphylaxis? Yes No Unsure

I am allergic to the following medications(s): _____
Does this cause anaphylaxis? Yes No Unsure

I am allergic to the following substances(s): _____
Does this cause anaphylaxis? Yes No Unsure

NUTRITION: We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark which of the following applies to your personal diet. Please call if you have any questions.

I eat a regular, varied diet.

I am lactose-intolerant. *our expectation is that you will bring your own supply or products (such as Lactaid) and will contact the health supervisor when the supplement is needed*

CHRONIC CONCERNS: Please mark all that pertain to you and provide information about supportive health care.

I have no chronic health concerns and am capable of full participation in this camp program.

I have the following chronic health concern(s):

- | | | | |
|--------------------------------------------------------|-------------------------------------------|--------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> headaches | <input type="checkbox"/> sleepwalking | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> hearing difficulties | <input type="checkbox"/> menstrual cramps | <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> bee sting allergies | <input type="checkbox"/> seizure disorder | <input type="checkbox"/> surgical history | <input type="checkbox"/> fainting |
| <input type="checkbox"/> other (please describe) _____ | | | |

Please provide information about supportive health care needed for each marked item (if any): _____

If *surgical history* is marked above, please explain: date of surgery _____ type of surgery _____

Are all symptoms resolved? Yes No - Please explain _____

Are you cleared by your physician for active camp participation? Yes No date of last tetanus shot _____

Physician name _____ Office phone (_____) _____

Dentist name _____ Office phone (_____) _____

MEDICATIONS: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if you have been taking the current dose for less than three months prior to arrival or if there are any changes

I do not take any medication

I take the following medication(s) *please use a separate sheet if necessary*

1. medication _____ reason for taking _____
dose taken _____ how often each day? _____

2. medication _____ reason for taking _____
dose taken _____ how often each day? _____

3. medication _____ reason for taking _____
dose taken _____ how often each day? _____

MEDICATIONS (continued)

The following medications are supplied to our health supervisor during the week of camp. They are used to manage illness or injury and are dispensed as directed by our medical protocols. Generic forms may be used. Please cross-out any medicine that SHOULD NOT be administered:

Acetaminophen (Tylenol)	Cough Drops	Hydrocortisone Cream	Neosporin
Alcohol Swabs	Cough Syrup	Ibuprofen (Motrin)	Pepto Bismol
Aloe	Chloraseptic	Insect Repellent	Pseudoephedrine
Antacid	Diphenhydramine (Benadryl)	Iodine Swabs	Tinactin
Calamine Lotion	Dramamine	Kaopectate/Anti-Diarheals	Triple Antibiotic Cream

MENTAL, EMOTIONAL AND SOCIAL HEALTH *(this information will only be made known to your director, cabin leader & health supervisor)*

Have you been diagnosed with ADD, depression, OCD, panic/anxiety disorder or had any other emotional, mental or social health concerns that continue to affect you or have prompted you to seek professional care? If so, please explain _____

BILLING INFORMATION FOR HEALTH CARE

You are financially responsible for health care given by an out-of-camp provider and for transportation home if the need arises. To whom should this provider route charges for your health care if you are sick or injured and need outside care? Please include a copy of your insurance card if appropriate. Please copy both sides of the card so addresses and telephone numbers are readable.

- I am not covered under any insurance policy.
- I am covered under the following health insurance.

Insurance Company _____ Policy/Member # _____
 Insurance Company Telephone (_____) _____ Name of Subscriber _____
 Insurance Co. Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

We will call your listed contacts in the event of an emergency or if we have questions about your health. Please provide contact information for people who know you and with whom we can consult if you cannot respond to questions. We will assume that you have spoken to these individuals and that are willing to assist, should the need arise.

Primary Contact _____ relationship to camper _____
 Home (_____) _____ Work (_____) _____ Cell (_____) _____
 Alternate Contact _____ relationship to camper _____
 Home (_____) _____ Work (_____) _____ Cell (_____) _____

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE & CONSENT (if under 18) This health history is correct and my child has permission to participate in all JEMS Mount Hermon activities except those noted by me and/or the examining physician or health supervisor. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to be transported by authorized vehicles if an emergency situation arises. JEMS has my permission to obtain a copy of my child's health record from the providers that treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for the health of my child. 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 my child. This form may be photocopied. I give permission to authorized JEMS staff to use video or photography of my child for promotional purposes.

SIGNATURE OF PARENT/GUARDIAN (if under 18) _____ DATE _____

PERSONAL AUTHORIZATION FOR HEALTH CARE & CONSENT This health history form is correct and I am capable of participating in the full JEMS Mount Hermon camp program apart from the exceptions noted above. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care while I participate in the camp program and the transport to and from any emergency (if necessary) JEMS has my permission to obtain a copy of my health record from my health providers. I understand that information about my health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for my health in case of an emergency. If my emergency contact cannot be reached, I give permission to the physician selected by JEMS to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my health. This form may be photo copied. I give permission to authorized JEMS staff to use video or photography for promotional purposes.

APPLICANT'S SIGNATURE (if 18 or over) _____ DATE _____