2025 Camper Application

Camp Cherokee rules for acceptance and participation are the same for everyone, without regard to race, color, creed or national origin.

Please type or print neatly. Must be signed by parent or guardian:

Camper's Name (Last, First, Middle) | Home/Cell Phone | Parent/Guardian Work Phone

Street/City/State/Zip

Date of Birth | Grade | Gender: ____ Male ___ Female

Home Church | Desires Baptism at Camp: ___ Yes ___ No

Email Address

Parents, Please Initial Applicable Statements (1&2 required)

____ I give my permission for a doctor or nurse to treat my child in the event of an emergency. My child suffers from no chronic illnesses. I understand that my own medical insurance policy will be applied to any medical/hospital costs incurred.

____ I have read the camp brochure and will comply with all regulations, policies and procedures stated therein.

____ I permit Camp Cherokee to use photographs of my child for promotional purposes.

____ I give permission to my child to participate in the following camp activities: horseback riding, tubing, swimming, archery, Rockwall climbing, crafts, and their described difficulty and risk level as outlined on www.campcherokeeadk.com.

____ I give permission for sunscreen and/or bug spray to be applied to my child.

____ I understand that registration begins at 2:00 pm in the cafeteria

____ I agree to the policies regarding electronic devices. I understand that this policy requires NO ELECTRONIC DEVICES in possession of the camper at camp throughout the duration of the week. I agree to not have any electronic devise (cell phones, iPhones, iPods, MP3 players, hand-help gaming devices, etc.) while I am at camp. I understand that any electronic device that is found in my possession will be confiscated. I understand that Camp Cherokee is not responsible for any device that is brought to camp. I agree that any confiscated device will be returned to me only at my payment of the required $25 fee at the end of the week.

Signature of Camper | Date

Signature of Parent/Guardian | Date

Fees: $483.00 ___ Picture - $5.00 ____ CD - $10.00 (***check box & include with total below.)***

Camp #	Camp Date	Camp Selection(s)	Camp Cost
1	June 29-July 6	Teen Camp	
2	July 6-13	Junior/Tween Camp	
3	July 13-20	Adventure Camp	

* $100 deposit is part of the total camper fee.
** If paid in full and postmarked by June 1st. *(No discount after June 1)*
*** If paying by credit card, a 3% surcharge will be added to the total.

Send completed application, Health History/Physical Exam, Release, and non-refundable deposit to:

Camp Cherokee/New York Conference
P O Box 15502, Syracuse, NY 13215

NY Conf. Member Discount ($25)		
Early Bird Discount ($25)**		
Store/Offering		
Picture/CD		
TOTAL* **		

$150 DEPOSIT REQUIRED WITH APPLICATION

This deposit is **non-refundable** unless cancellation is two weeks prior to Camp.

For Office Use Only

Date	Rec#/Ck#	Total Ck	Fee	Store	Offering	Picture	DVD	Balance

Children's Camper Health History/Physical Exam Form

FILL IN ALL REQUESTED INFORMATION OR ENCLOSE A COPY OF PHYSICAL AND IMMUNIZATION RECORDS

Camper Name_____

Physical Examination - To be filled out by a licensed provider (i.e. MD, PA or NP).

New York State law requires a signed/dated physical exam, within the last 12 months and dates of most current boosters

Immunization History - **MUST BE COMPLETED WITH DATES OR ENCLOSE A COPY.** Please record the date (month and year) of basic immunizations and most recent booster doses:

___ DPT or DT ___Tuberculosis ___ COVID Vaccine ___ Hepatitis vaccination ___ Chicken Pox Vaccine

___ MMR ___ Polio vaccine (most recent) ___ Pneumonia vaccination ___ Recent exposure to contagious disease ___ Flu vaccine

General Condition or Appraisal – Complete if physical not included*

Birthdate _____ Nutrition_____ Allergy Athlete's foot_____

Height _____ Nose _____ Foods_____ Impetigo _____

Weight_____ Throat-tonsils_____ Drugs_____ Infection _____

Posture & Spine_____ Lungs _____ Other_____ Pediculosis _____

Feet_____ Eyes Abdomen_____ Describe Current conditions (diabetic, seizures, emotional issues, etc.)_____

Teeth _____ Discharge _____ Genitals_____ _____

Blood pressure_____ Glasses_____ Hernia _____ _____

Heart murmur _____ Menstruation_____ Skin _____

Ears_____ Urine _____ Scabies_____ _____

Standard Over the counter/PRN medications: (The following medications are available in the infirmary and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider i.e. MD, PA, or NP). The provider must initial each medication approved.

Drug Name	Route (indicate formulation[s])	Dosage	Schedule & Indications	**HEALTHCARE PROVIDER INITIALS**	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (prn)		
Acetaminophen (Tylenol)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 4 hr prn for pain or fever >_____^{0}F		
Ibuprofen (Motrin)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever >_____^{0}F		
Diphenhydramine Hydrocholoride (Benedryl)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream or Benadryl Cream	Topical	Per label instr. by age/weight	prn - itching		
Tums	Chewable tab	Per label instr. by age/weight	No>10 tabs/24 hrs		
Throat Lozenges/Cough Drops	Tab	1 Lozenge	No>6/24 hr		

Prescription Medications (please complete with patient's current regimen for both scheduled and prn medications. Use additional page if needed.)

Drug	Route	Dosage	Schedule & Information	Comments

Additional Orders (as deemed necessary by healthcare provider to be implemented by an RN (i.e. peak flows, dressing changes, cast care, etc.). Multivitamins must be included if taking, as well as OTC such as Melatonin.

I BELIEVE THIS CHILD IS ABLE TO ATTEND CAMP AND PARTICIPATE IN ALL CAMP ACTIVITIES WITH THE FOLLOWING RESTRICTIONS AND RECOMMENDATIONS (ATTACH SPECIFIC INSTRUCTIONS OR MEDICATIONS, TREATMENTS AND DIET, RESTRICTIONS OR CONSIDERATIONS):

Provider's Name (print) _____ License #: _____

Providers Signature _____ Date: _____

Address: _____ Phone: _____

*** RN MAY ONLY GIVE THOSE LISTED AND/OR INITIALED! NO EXCEPTIONS.**

Children's Camper Health History/Physical Exam Form

Fill in all requested information. Incomplete forms cannot be processed and will be returned. Forms are due two (2) weeks before your child's session begins.

Mail to: **Camp Cherokee, c/o New York Conference of SDA, P O Box 15502., Syracuse, NY 13215**

Please Print (**THIS SIDE AND TOP OF BACK PAGE TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAMINATION**).

Camper Name_____ Birth date:_____ Age _____ Sex _____ Home/Cell Phone_____
Parent/Guardian _____ Home Address_____
Business Address_____ Business/Cell Phone_____
Other Parent/Guardian_____ Home Address:_____ Home Phone_____
Business Address_____ Business/Cell Phone _____
In the event of emergency, and parent or guardian cannot be reached, notify _____ Relationship to camper_____
Address_____ Home Phone_____ Business/Cell Phone_____

Note:

This person must be a relative over 18. If someone is not a relative, a "notarized statement" authorizing that person to approve medical treatment is necessary. In the event of an injury or illness that does not require removal to a hospital, parents shall not be notified unless medical personnel's concerns dictate. When injuries or illnesses require a trip to the hospital, either the RN accompanying the camper or the camp director or their designee will notify the parents.

Health History - To be completed by **PARENT/GUARDIAN** *(give approximate date of illness or 'no" if not applicable)*

___ frequent ear infections
___ heart defect/disease
___ diabetes
___ seizures
___ hypertension
___ psychiatric treatment
___ sleep walking
___ menstrual issues
___ bleeding/clotting
___ bed wetting
___ fainting
___ asthma

Allergies
___ hay fever ___ other
___ plants ___ insect stings
___ food:_____
_____
___ animals

Diseases
__ chicken pox
__ measles
__ German measles
__ mumps
__ whooping cough

Medication Allergies/Reaction:_____
Current medication (send in original container with instructions):_____
Operations or serious injuries (dates):_____ Disability of chronic or recurring illness:_____
Dietary modifications:_____ Any specific activities limited:_____
Name of dentist/orthodontist:_____ Phone:_____
Name of family physician:_____ Phone:_____

Medical Insurance

Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.

Authorization for release for information to above named insurance carrier

Signature_____ Date_____ Relationship to camper (parent, etc.)_____

Address of Insurance Company

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.

IMPORTANT - This Box Must Be Completed For Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine test, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Director to secure and administer treatment, including hospitalization, for my child, as named above. The completed forms may be photocopied for trips out of camp.

Meningococcal Meningitis Vaccination Response

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response for every camper who attends camp for seven (7) or more nights. Please check one box and sign below.

__ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received:_____
Note: The vaccine's protection lasts for approximately 3 to 5 years. Re-vaccination may be considered within 3-5 years)

__ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signature of parent or guardian_____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor _____

Licensed physician to fill out back of this form

CAMP CHEROKEE

"Changing Lives – Making Memories"

Summer Camp:
433 Gilpin Bay Road
Saranac Lake, NY 12983
Phone: (518) 891-3520
Fax: (518) 897-2134

Syracuse Headquarters:
Phone: (315) 469-6921
Fax: (315) 469-6924

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Camp Cherokee is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parent or guardian; AND EITHER
- A record of meningococcal meningitis immunization OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,00-1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotic, 10-15% of these people die. Of those who live, another 11-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger. For example, 2 MCV4 vaccines are Menactra™ and Menveo™.

  The Centers for Disease Control and Prevention recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first does at 11 or 12 years of age, with a booster does at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

  If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

New York Conference
of Seventh-day Adventists
Youth Ministries

4930 W. Seneca Turnpike
Syracuse, N.Y. 13215

- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55. The trade name of MPSV4 is Menomune.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

To learn more about meningitis and vaccine, please feel free to contact your child's physician. You can also find information about the disease a the website of the Center for Disease Control and prevention: www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Sincerely,

Dan Whitlow
Director