

2012 Military-Extension Adventure Camps!

The University of Kentucky Family and Consumer Sciences Extension is offering four FREE high-adventure camps this summer for military service member parents (service member or spouse) and their teenage children ages 14-18 to attend together! The camps are open to military parents and teens from any state and branch of the military, including Active Duty, Reserve, and National Guard. Priority will go to families who have experienced at least one deployment and who are geographically dispersed.

Camp Schedule:

1. **June 11-16: Whitewater Rafting & Outdoor Extravaganza**
ACE Adventure Resort in Oakhill, WV
2. **July 5-8: Big South Fork Whitewater Canoeing & Backpacking Expedition**
Big South Fork River near Stearns, KY
3. **August 31-September 2: Wounded Warrior Camp**
Center for Courageous Kids, Scottsville, KY
4. **September 14-16: Caving, Rappelling, & Rock Climbing Expedition**
Old Life Adventure Center, Irvine, KY

To sign up for camp, please complete this application and return to Lauren Smith at the address below. If you and your child/children are accepted to attend the camp, you will receive an e-mail with all the information you need for that camp prior to the start of the camp. If you have any questions, contact Lauren Smith, Military-Extension Adventure Camps Coordinator, at 859-257-3072 or lauren.w.smith@uky.edu.

Everything at the camps, including all meals, is FREE! Once you mail in your application and are notified of your acceptance to attend the camp, you will receive a registration fee form explaining that there is a \$15/person non-refundable registration fee in order to hold your registration spot at the camp. Pack your bag and get your family ready for a fun experience shared with other military parents and teens! We look forward to seeing you and enjoying a wonderful adventure with you.

Return registration forms to: Lauren Smith – Military-Extension Adventure Camp Coordinator
 University of Kentucky
 115 Huguelet Dr.
 Scovell Hall, Room 242
 Lexington, KY 40546-0064

Must submit completed, signed application by regular mail. Faxed or emailed copies will NOT be accepted.



Military-Extension Adventure Camps Registration Form

Pages 2-4 – Fill out ONCE for whole family

Pages 5-11 – Fill out for EACH participating family member

Please print clearly.

CHOOSE THE CAMP YOU WISH TO ATTEND:

Today's Date: _____

*If you mark more than one, please indicate your first choice.

- ____ June 11-16: Whitewater Rafting & Outdoor Extravaganza
- ____ July 5-8: Big South Fork Whitewater Canoeing & Backpacking Expedition
- ____ August 31-September 2: Wounded Warrior Camp
- ____ September 14-16: Caving, Rappelling, & Rock Climbing Expedition

Primary Contact Name: _____ Name of Service Member in Family: _____

Family Members Attending Camp:

Family Member #1: _____ Gender: _____ Age: _____

Family Member #2: _____ Gender: _____ Age: _____

Family Member #3: _____ Gender: _____ Age: _____

Family Member #4: _____ Gender: _____ Age: _____

(Please add additional family members on back if more space is needed. Children must be 14-18 years old at the time of camp.)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail for primary contact: _____

Child(ren)'s Address (if different than parent/or guardian attending camp): _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact Name (other than someone attending): _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email: _____



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Military-Extension Adventure Camps Registration Form

Deployment Status of Service Member in Family (check one):

- Never deployed and no plans to deploy
- Never deployed but may deploy in the future
- Have been deployed once
- Have been deployed more than once

Branch of Service:

- Air Force
- Marines
- Army
- Navy
- Coast Guard

Please Circle One: Active Duty Reserve National Guard

Rank of Service Member (Optional): _____

How did you hear about our camps?

- Unit Family Readiness Group
- Email list
- ISFAC
- Operation: Military Kids
- Unit Newsletter
- Other (please specify): _____

Any special accommodations needed for a family member? If so, please list:

Any special dietary needs for a family member? If so, please list:

Note: Priority for slots at each camp will be done by date registration is received. If a camp is full, you will be put on a waitlist for that camp or given the option to attend a different camp that is still open. If your family is selected for the camp, you will be contacted. You will then receive a participant packet prior to that camp that will include: general instructions, camp rules & guidelines, a packing list, directions, an agenda, and emergency numbers. Once all slots are filled, any registrants who are not initially selected will be placed on a wait list and you will be notified accordingly.

Military-Extension Adventure Camps

Rules & Regulations

1. **Absolutely no alcoholic beverages, drugs, explosives, or firearms are allowed on camp premises.**
2. **No smoking allowed in any building.** Smoking is allowed only in marked areas.
3. Shoes should be worn at all times unless otherwise instructed by a camp staff member.
4. Parking is permitted only in marked areas. Driving and parking instructions will be included in your Participant Packet.
5. No pets are permitted anywhere on the camp grounds. Service animals are allowed.
6. A life jacket **MUST** be worn at all times by anyone around waterfront areas and while in boats.
7. This is a time to connect with your family. Cell phones should be used in emergencies only.
8. In the event of an injury to anyone in your family, notify camp staff immediately. An incident report form must be completed for any injury that occurs.
9. Please notify Lauren Smith of any medical or health problems of family members **BEFORE** you come to camp. She will inform medical and camp staff.
10. It is the responsibility of the parent or guardian to supervise their children at camp at all times.
11. There is a zero-tolerance policy at camp for bullying, fighting, physical or verbal abuse, sexual harassment, inappropriate touching, or corporal punishment of children. Anyone violating this rule will be asked to leave the camp premises immediately.
12. Families are responsible for the cleanliness of the facility. It should be as clean when you leave as it was when you arrived.
13. It is the responsibility of the parent or guardian to make sure children understand and know all the rules **BEFORE** attending camp.

By signing this form, I understand that if I do not meet these expectations, I may be dismissed from camp and will be responsible for transportation off the premises.

Parent/Guardian Signature

Date

Military-Extension Adventure Camps Health Form

Pages 5-11 – Fill out for EACH participating family member

The information on this form is not part of the camper or staff acceptance process. Health history must be filled out by parents/guardians of minors or by adults themselves and is gathered to assist us in identifying appropriate care. Update is required annually.

Name _____ Birth Date _____ Age at time of camp _____
Last First Middle

Home Address _____
Street Address City State Zip

Phone _____ [] Male [] Female

Race* Check all that apply: [] American Indian [] Asian [] Black [] Pacific Islander [] White

[] Hispanic [] Non-Hispanic *Necessary to comply with affirmative action-Civil Rights Standard

Custodial parent/guardian _____ Phone: _____ Cell: _____

Home Address _____
Street Address City State Zip

Business Address _____ Phone: _____
Street Address City State Zip

Second Parent or Guardian or Emergency Contact _____ Cell _____

Address _____ Phone: _____
Street Address City State Zip

If not available in an emergency, notify: _____
Name Relationship Phone

****IMPORTANT- THIS BOX MUST BE COMPLETE FOR ATTENDANCE****

Parent/Guardian Authorizations: this health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over the counter medication, assist in administering camper's prescription medications as needed, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including trips out of camp.

Signature of parent/guardian (or adult volunteer/staff): _____

Printed Name: _____ **Date:** _____

General Questions (Explain "yes" answers below.)



Disabilities accommodated with prior notification.

Has/does the Participant:	Yes	No		Yes	No
1} Had any recent injury, illness or infectious disease?	[]	[]	16} Ever had back problems?	[]	[]
2} Have a chronic or recurring illness/condition?	[]	[]	17} Ever had problems with joints; e.g., knees, ankles?	[]	[]
3} Ever been hospitalized?	[]	[]	18} Have an orthodontic appliance being brought to camp?	[]	[]
4} Ever had surgery?	[]	[]			
5} Have frequent headaches?	[]	[]	19} Have any skin problems (e.g., itching, rash, acne)?	[]	[]
6} Ever had a head injury?	[]	[]	20} If female, have an abnormal menstrual history?	[]	[]
7} Ever been knocked unconscious?	[]	[]	21} Had problems with diarrhea/constipation?	[]	[]
8} Wear glasses, contacts or protective eye wear?	[]	[]	22} Had mononucleosis in the past 12 months?	[]	[]
9} Ever had frequent ear infections?	[]	[]	23} Have diabetes?	[]	[]
10} Ever passed out during or after exercise?	[]	[]	24} Had problems with sleepwalking?	[]	[]
11} Ever been dizzy during or after exercise?	[]	[]	25} Have asthma?	[]	[]
12} Ever had an eating disorder?	[]	[]	26} Have a history of bed-wetting?	[]	[]
13} Ever had chest pain during or after exercise?	[]	[]	27} Ever had seizures?	[]	[]
14} Ever had high blood pressure?	[]	[]	28} Ever had emotional difficulties for which professional help was sought?	[]	[]
15} Ever been diagnosed with a heart murmur?	[]	[]			

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had?	Please give all dates of immunization for:						
Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
[] Measles	DTP	_____	_____	_____	_____	_____	_____
[] Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
[] German measles	Tetanus	_____	_____	_____	_____	_____	_____
[] Mumps	Polio	_____	_____	_____	_____	_____	_____
[] Hepatitis A	MMR	_____	_____				
[] Hepatitis B	or Measles	_____	_____				
[] Hepatitis C	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____		
Date of last test	Hepatitis B	_____	_____	_____			
Result [] Positive [] Negative	Varicella (chicken pox)	_____					

Health History: The following information must be filled in by the parent -guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known

Describe reaction and management of the reaction.

Medications allergies (list)

Food allergies (list)


Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

Please list any **DIETARY RESTRICTIONS** that apply to this individual. _____

Insurance Information

Is the participant covered by family medical/hospital insurance? [] Yes [] No

If so, indicate carrier or plan name: _____ Group # _____

 Photocopy of front and back of health insurance card or current K-chip must be attached to this form.

Is there any additional information that camp staff should know to help your child be successful and have fun at camp?
(behavioral, physical, emotional, special restrictions, etc.) _____

If your child receives medication during the school year, we strongly urge you to keep your child on this medication during camp.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

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ADULT

General Use Specific Project: _____

I, (*print full name*) _____, being eighteen (18) years of age or over, hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association and UK Research Foundation, to interview, photograph, and/or videotape me; and/or to supervise any others who may do the interview, photography, and/or videotaping; and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

Please check all that apply:

- UK Educational Publications/Videos
- UK Electronics Publishing (e.g., World Wide Web)

- UK Promotion/Advertising
- Local/Regional/National News Media (w/ permission of UK)

Signature: _____
Signature

Date: _____

Witness: _____
Signature

Date: _____

Name and mailing address (please print)

Name: _____

Address: _____

E-mail: _____ Phone: _____

Send copy of form to:
University of Kentucky
Agricultural Communications Services
131 Scovell Hall
Lexington, KY 40546-0064

MINOR CHILD

General Use Specific Project: _____

I, (*print full name*) _____, hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association and UK Research Foundation to interview, photograph, and/or videotape my minor child, _____, and/or to supervise any others who may do the interview, photography, and/or videotaping; and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

Please check all that apply:

- UK Educational Publications/Videos
- UK Electronics Publishing (e.g., World Wide Web)

- UK Promotion/Advertising
- Local/Regional/National News Media (w/ permission of UK)

Signature of Parent or Guardian: _____
Signature

Date: _____

Relationship: _____

Witness: _____
Signature

Date: _____

MEDICAL INSURANCE INFORMATION FORM

Participant Name: _____		
Last	First	Middle I.
Address: _____		
Street	Apt. #	

City	State	Zip Code
Participant's Social Security No.: _____		
Age: _____		Date of Birth: _____
Parent/Guardian Name(s): _____		
Business phone:	mother: _____	step mother: _____
	father: _____	step father: _____
Home phone:	mother: _____	step mother: _____
	father: _____	step father: _____
Neighbor or Relative (Other than parent/guardian): Phone: _____		

PRIMARY INSURANCE INFORMATION

PARENT'S INSURANCE COVERING PARTICIPANT	
Insured: _____	Date of Birth: _____
Policy No.: _____	Member ID #: _____
Insurance Co.: _____	Phone #: _____
Insurance Co. Address.: _____	

SECOND PARENT'S INSURANCE (if participant is also covered under this policy)	
Insured: _____	Date of Birth: _____
Policy No.: _____	Member ID #: _____
Insurance Co.: _____	Phone #: _____
Insurance Co. Address.: _____	

◆ Check and sign if participant has no health coverage.

There is no health insurance coverage for this participant at this time.	
Signature Parent/Guardian.: _____	Date: _____

You MUST submit a copy of the front and back of all insurance and Rx identification cards covering participants.

Insurance Carrier

CIGNA

Coverage

Insurance coverage is on an **excess** basis only. The participants' personal health insurance policy will be primary and provide coverage for accident and sickness. The **excess** policy will cover any out-of-pocket expense not paid by the participants' personal insurance up to the limits of the policy listed below. (This includes payment of the deductible and coinsurance amounts if applied under the participants' personal policy.) The sickness medical expense will be limited to \$500 on an **excess** basis. The benefit period is one year. The first expense must be incurred within 60 days of the accident or sickness. If the participant does not have personal health insurance coverage, this **excess** policy will pay first dollar, up to the limits of this policy. Pre-existing conditions are not covered. A pre-existing condition is any condition for which a prudent person should have sought treatment or was treated in the previous six months

Coverage Benefits & Limits

Accident Medical Expense (Excess)	\$25,000
Accident Dental Expense (Excess)	Included
Deductible	Nil
Sickness Medical Expense (Excess)	\$500
Deductible	Nil
AD&D and Paralysis, Principal Sum	\$10,000
Benefit Period	One Year
Effective Date	1/1/11
Expiration Date	1/1/12

Consent to Medical Treatment/Insurance Statement

It is understood that authority is given to the University of Kentucky, or anyone they may designate, to have my son/daughter treated for injuries or illnesses they incur during a designated camp, conference, or field trip activity at the University of Kentucky.

I understand that I will be notified if a health problem arises, but in the event I cannot be reached by telephone, I hereby give the University of Kentucky, or anyone they may designate, permission to seek medical treatment for the participant named below, including surgery (on an emergency basis) or additional advanced treatments (MRI, lab tests, etc.) as deemed necessary by competent medical personnel.

I am aware that, as the adult participant, or as the parent or legal guardian of the participant named below, I will be responsible for any expenses incurred outside of the limits provided by the University of Kentucky's Camps/ Conference/Field Trip Policy. I also understand that the University of Kentucky insurance coverage is on an "excess" basis only. The excess policy will cover any out-of-pocket expense not paid by the participant's personal insurance up to the limits of the policy listed above.

_____ Date Name of Participant Signature (Parent or Guardian if claimant is a minor)

Emergency Contact (if other than parent)

Name: _____ Relationship: _____

Phone number: (home) _____ (work) _____

AUTHORIZATION TO RELEASE INFORMATION		
<p>I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to any CIGNA company, the Plan administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.</p>		
Signature (Parent or Guardian if claimant is a minor)	Date	Phone No.
<p>PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.</p>		
Signature (Parent or Guardian if claimant is a minor)	Date	