MEPHIBOSHETH MINISTRIES

Camp Mephibosheth Overnight Application

Please Complete ALL Items

Camper Information

Camper's Name: _____ Sex: _____ Age: _____ Birthdate: _____
Mailing Address: _____ Home Church: _____
City, State Zip: _____ T-shirt Size (S-XXL): _____
Home Phone: _____

Please Check One: ◯ Group Home ◯ Private Residence ◯ Facility ◯ Supportive Living

Person(s) Responsible

Parent/Care Provider Name: _____ Home Phone: _____
Mailing Address: _____
City, State, Zip: _____ Email: _____

Person(s) Responsible for Transportation To and From Camp

Name: _____ Daytime Phone: _____
Mailing Address: _____ Evening Phone: _____
City, State, Zip: _____ Email: _____

Who should confirmation materials be sent to? _____

Emergency Contacts

Please designate the person(s) to contact in the event of an emergency if we are unable to reach the primary contact.

Name: _____ Phone: _____
Mailing Address: _____ Alt. Phone: _____
City, State, Zip: _____ Relationship to camper: _____

Name: _____ Phone: _____
Mailing Address: _____ Alt. Phone: _____
City, State, Zip: _____ Relationship to camper: _____

Name: _____ Phone: _____
Mailing Address: _____ Alt. Phone: _____
City, State, Zip: _____ Relationship to camper: _____

Disability Information

Please list all disabilities including developmental and physical: _____

Please check all that apply:

Legs: ☐ R ☐ L Arms: ☐ R ☐ L Hands: ☐ R ☐ L ☐ Head ☐ Breathing

Mobility

Independent with ○ Assistance ○ Walker ○ Crutches ○ Wheelchair* ○ Electric wheelchair*

*If in a wheelchair: ○ Propels Self ○ Must be pushed

For non-ambulatory campers, it is the responsibility of the parent/guardian/caregiver to provide a wheelchair and any necessary augmentative device that is safe and in operational condition. Be certain wheels, brakes and seatbelts are safe and fully operational.

Vision

○ Normal ○ Glasses ○ Contacts ○ Vision Impaired ○ Legally Blind

Hearing

○ Normal ○ Hard of Hearing ○ Deaf ○ Hearing Aids *Bring extra batteries*

Communication

☐ Verbal ☐ Speech Difficulty ☐ Nonverbal ☐ Signs ☐ Gestures ☐ Communication Board

Seizure Disorder

Type and frequency: _____

Wears helmet ○ Yes ○ No Date of Last Seizure: _____

Special care for seizures: _____

Level of Care Required

Showering ○ Independent ○ Verbal Reminders ○ Assistance in/out of the shower ○ Needs Total Assistance

Partial Assistance ☐ Brushing Teeth ☐ Hair ☐ Washing Upper Body ☐ Washing Lower Body ☐ Shaving

Toileting ☐ Uses Urinal/Toilet ☐ Uses Bedpan ☐ Catheterizes Self ☐ Must be Catheterized ☐ Wears Depends ☐ Prompts after toileting ☐ Assistance after toileting

Mealtime ☐ Uses Utensils ☐ Uses Fingers ☐ Special Container ☐ Requires Bib ☐ Uses Straw

Dietary Restrictions: _____

Special Foods/Textures: _____

Other Mealtime Provisions: _____

Nighttime ☐ Nighttime Incontinence ☐ Wears Depends ☐ Gets Up At Night ☐ Develops Bedsores

Sleeps on ☐ Back ☐ Stomach ☐ Side ☐ R ☐ L

Other nighttime considerations: _____

Other

Allergies: _____

Precautions/Special Instructions: _____

Other Needs: _____

Discipline/Inappropriate Behavior Concerns: _____

Likes/Dislikes: _____

Reading Skill: ○ Yes ○ No ○ With Assistance Writing Skill: ○ Yes ○ No ○ With Assistance

Other Pertinent Information that would be helpful for staff: _____

Has this individual ever been a victim of abuse? ○ Yes ○ No

Please explain: _____

Has this individual ever been charged with abuse or related misconduct? ○ Yes ○ No

Please explain: _____

MEPHIBOSHETH MINISTRIES

Camp Mephibosheth Health History

Camper Information

Camper's Name: _____ Sex: _____ Age: _____ Birthdate: _____
Mailing Address: _____
City, State Zip: _____
Home Phone: _____

Person(s) Responsible

Parent/Care Provider Name: _____ Home Phone: _____
Mailing Address: _____
City, State, Zip: _____ Cell Phone: _____

Emergency Contacts

Please designate the person(s) to contact in the event of emergency if we are unable to reach the primary contact.
Name: _____ Phone: _____
Mailing Address: _____ Alt. Phone: _____
City, State, Zip: _____ Relationship to camper: _____

Health History:

Check and give approximate dates

- ☐ Frequent Ear Infections _____
- ☐ Heart Defect/Disease _____
- ☐ Seizures _____
  Describe _____
- ☐ Diabetes _____
- ☐ Bowel _____
- ☐ Bladder _____
- ☐ Bleeding/Clotting Disorders _____
- ☐ Hypertension _____
- ☐ Mononucleosis _____
- ☐ Psychiatric Treatment _____
- ☐ Asthma _____

Health History Comments:
_____

Diseases:

- ☐ Chicken Pox _____
- ☐ Measles _____
- ☐ German Measles _____
- ☐ Mumps _____

Allergies: (Dates not needed)

- ☐ Hay Fever
- ☐ Ivy Poisoning, etc.
- ☐ Insect Stings
- ☐ Penicillin

Other Drugs (specify)_____
Other (specify)_____
Reactions:_____

Height _____ Weight_____
Operations or serious injuries (dates) _____
Disability or chronic or recurring illness _____
Activities encouraged or limited by physician_____
Dietary modifications _____
Other diseases or details of above _____
Dentist / Orthodontist _____ Phone _____
Family Physician _____ Phone_____
Date of last physical examination _____
For Female: Has this person menstruated? ○Y ○N
If not, has she been told about it? ○Y ○N
If so, is her menstrual history normal? ○Y ○N
Explain: _____
Special considerations_____
Additional Health History Comments: _____

Insurance

Do you carry family medical / hospital insurance? ○Y ○N
If so, indicate: Carrier_____
Policy or Group #_____

Date of Last Tetanus Shot _____

Medications MUST be in original bottle!!

MEDICATION NAME	DOSE (How Much is Given Each Time)	FREQUENCY: (Times of Day Meds are Given)	WHAT IS MEDICATION GIVEN FOR?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

OVER THE COUNTER MEDS	DOSE	HOW OFTEN
☐ Tylenol		
☐ Ibuprophen		
☐ Milk of Magnesia		
☐ Maalox or Tums		

I, the undersigned, hereby represent that I am myself, the parent or legal guardian of this camper, and state that the health history is correct so far as I know. I agree that I/he/she may participate in the program at Camp Mephibosheth and The Ark Christian Ministries. I consent that in event of sickness or accident of any nature, Mephibosheth Ministries, Inc. or The Ark Christian Ministries will not be held responsible or liable.

With the realization that in such eventuality personal notification may not be possible or practicable, I authorize Mephibosheth Ministries, Inc. and The Ark Christian Ministries to render any aid and assistance to help my camper; to call emergency medical personnel if necessary, who may take any measure deemed necessary to help this camper.

I authorize Mephibosheth Ministries, Inc and/or The Ark Christian Ministries to release this camper's medical information to paramedics or other health care professional in the event medical care is needed.

I give the staff of Mephibosheth Ministries, Inc. permission to give medication to the camper on my behalf.

I agree to pay for any prescribed medication or treatment my camper may need.

This authorization shall continue to be in effect as long as my camper is a participant in the program at Mephibosheth Ministries, Inc.

Signature_____ **Relationship** _____**Date**_____

Type your name, relationship and date. You will sign the document when you check-in at camp.

MEPHIBOSHETH MINISTRIES

Camp Mephibosheth

Camper Participation Consent and Liability Release

Full Name of Camper _____ **Birthdate** _____

- I certify that the information provided on the application is true and accurate to the best of my knowledge. I assume full responsibility for all property belonging to the above named camper. I will not hold Mephibosheth Ministries, Inc., *The* Ark Christian Ministries, or any Camp Mephibosheth staff responsible for any damage to or loss of said property.
- I hereby consent to participation of myself or the person named above in all of the Camp Mephibosheth events. I am aware that in addition to activities such as Bible study, worship, transportation, and meal functions, the participant also may participate in various camp activities that may involve additional risks, such as swimming, fishing, canoeing, hiking, crafts, group initiative rope course (flying squirrel) and other recreational activities.
- All camp activities are modified to suit the individual camper, according to the camper's abilities, and all activities are closely supervised with staff and volunteers. Please complete the section below to indicate permissions for the camper named above.

Camper has permission to participate in ALL camp activities: ○ **Y** ○ **N**

If no, please list activities camper does not have permission to participate in:

_____

Activities include, but are not limited to, the following: group games, swimming, hiking, fishing, mudslide, zip line swing, climbing wall, canoeing, flying squirrel/chair swing, horseback riding.

I hereby release Mephibosheth Ministries, Inc. and / or The Ark Christian Ministries and its leaders from any liability arising from the participation in these high adventure activities.

- I hereby release Mephibosheth Ministries, Inc. to share information on this camper with the Team Leader and Volunteer Companion that will assist them during this camp experience. Confidentiality is stressed to all members of the faculty.
- I hereby give permission for the above-named camper to appear in photographs or video recordings made during Camp Mephibosheth. This permission also extends to the use of those photographs or video recordings in promotional presentations made by Mephibosheth Ministries, Inc.

Please type your name and date below. You will sign the document when you check-in at camp.

_____ _____

Parent/Guardian/Caregiver Date

_____ _____

Camper Date

Baptism Preferences

In our efforts to meet the spiritual needs of our campers during Camp Mephibosheth, we offer an opportunity for them to follow Christ's teachings to be immersed in baptism. ***Should this camper make this decision, we will follow your instructions as indicated below.*** If you have any questions about our belief regarding baptism by immersion, please call us. We welcome the opportunity to discuss this matter with you.

If _____ chooses to be baptized (Please check one)

○ I authorize Mephibosheth Ministries, Inc. and the camp to perform the baptism.

○ I prefer to have my minister perform the baptism at our home church.

○ I request to be present at the baptism.

○ Has already been immersed.

○ May not be baptized.

MEPHIBOSHETH MINISTRIES

Camp Mephibosheth

Please register me for:

_____ **Session #1** June 27 – June 29
Ends at 7:00 PM Monday

_____ **Session #2** July 1 – July 3
Ends at 3:00 PM Friday

Name _____

Address _____ Phone _____

Email Address: _____

Please list any other camper you will be attending with (group homes, etc.)

Camp Fee: $250
Minimum deposit of $100 to register
Balance due by June 1st

MEPHIBOSHETH MINISTRIES

Overnight Camp

List of clothing and personal items needed for camp

Camper's Name _____

This checklist shows the total number of articles suggested for our session of camp. Mephibosheth Ministries, Inc. does not assume responsibility for personal items brought to camp, but every effort will be made to see that campers will return home with all of their belongings. Do not pack toys, games, tape players, stereos, game boys, etc.

1. Mark all clothing with marking tapes sewn on or write your camper's name (first and last) in waterproof ink. Sew tapes or write name at the back neckline on shirts, etc. at rear waist on pants and on the corners of towels, washcloths and blankets. All other toiletry items should be marked with the name on adhesive tape with waterproof ink. Camper's name must be also marked on the outside of the sleeping bag.

2. IMPORTANT!! Pack inexpensive or used, older clothing. This is strongly suggested as things wear out or sometimes get lost at camp. Spending money is not needed, as all snacks are covered in the fee.

3. Put camper's name on OUTSIDE and INSIDE of suitcase.

SUGGESTED ESSENTIAL ITEMS

Complete the list below and tape it inside the camper's suitcase. Indicate in the blank spaces the number of each article brought to camp. (Numbers shown are suggested amounts of each article)

Sleeping Bag / Bedding	____ 1	**T-Shirts**	____ 3
Pillow	____ 1	**Pants or Shorts**	____ 1
Bath Towels	____ 1	**Pairs of Shorts**	____ 3
Wash Cloths	____ 2	**Sweatshirt**	____ 1
Pairs of Socks	____ 3	**Jacket**	____ 1
Underwear	____ 3	**Bug Repellent**	____ 1
Swimsuit	____ 1	**Toiletry Articles**: soap, deodorant,	
Beach Towel	____ 1	toothbrush, shampoo, shaving,	
Pajamas	____ 1	equip. hairbrush, comb, hair ties	
Hat or Cap	____ 1	**Sunscreen and Sun Glasses**	
Water Bottle			

If your camper sometimes soils underwear or wears diapers, please send a 3+ day supply.

3522 N 1000 W 27, Converse, IN 46919
Office: 765-395-3638 Fax: 765-395-3819
Email: theark@thearkcm.org
Web: www.thearkcm.org
Find us on Facebook & Instagram

Group/Program Name: Camp Mephibosheth

THE ARK CHRISTIAN MINISTRIES
RELEASE AND WAIVER OF LIABILITY,
ASSUMPTION OF THE RISK, AND INDEMNITY

RELEASE AND WAIVER OF LIABILITY: I, for myself, my heirs, next of kin, personal representatives and assigns, hereby release, waive, discharge, and covenant not to sue THE ARK Christian Ministries, its successors and assigns, the agents and board members of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities and events take place, from all liability, loss, claims, demands, possible causes of action, court costs, attorneys' fees and other expenses arising from any lawsuit that may otherwise accrue from any loss, damage or injury (including death) to my person or property in any way resulting from, or arising in connection with, or related to, any sanctioned event or activity, and whether arising while engaged in an activity or event, or while upon, entering or departing from said premises, from any cause whatsoever included, without limitation, specifically including but not limited to exposure to any communicable disease, such as COVID-19, the failure of anyone to enforce rules and regulations, the failure to make inspections, or the negligence of other persons, specifically including the negligence of THE ARK Christian Ministries, the agents and board members of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities or events take place.

ASSUMPTION OF RISK: I know the risk and danger to myself and property, both from known risk and unanticipated risk, while participating or assisting in a sanctioned activity or event (these risks include but are not limited to: head injury, bone breaks, and exposure to one or more communicable diseases, such as COVID-19) and I do so willingly, voluntarily and in reliance, not upon the property, equipment, facilities, and existing conditions furnished by others, including THE ARK Christian Ministries, the agents and board members of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities or events take place, but upon my own judgment and ability, and I thereby assume all risk of loss, damage, or injury (including death) to myself and my property from any cause whatsoever and whether or not attributable to the negligence of others, specifically including the negligence of THE ARK Christian Ministries, the agents and board members of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities or events take place.

INDEMNITY: I hereby agree to indemnify and hold harmless THE ARK Christian Ministries, the agents and board members of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities or events take place from loss, liability, damage, or cost they may incur due to my presence at or participation in any THE ARK Christian Ministries-sanctioned activity or event, whether caused by the negligence of THE ARK Christian Ministries, the agents and board members, of THE ARK Christian Ministries, any THE ARK Christian Ministries volunteers or employees, and the owners and lessees of premises on which THE ARK Christian Ministries-sanctioned activities or events take place or otherwise.

PUBLICITY RELEASE: I give to THE ARK Christian Ministries, its assigns, licensees, successors in interest, and legal representatives the irrevocable right to use any images derived from my presence at or participation in any THE ARK Christian Ministries-sanctioned activity or event in all forms and in all media and in all manners, without any restriction as to changes or alterations, for advertising, trade, promotion, exhibition, or any other lawful purpose. I agree that THE ARK Christian Ministries owns the copyright in these images, and I hereby waive any claims I may have based on any usage of the photographs or works derived therefrom, including but not limited to claims for either invasion of privacy or libel.

Participant Name (print)	Participant Signature	Participant Birth Date	Today's Date

Participant Address	City	State	Zip	Participant/Guardian Email Address

Emergency Contact Name	Emergency Contact Phone #

Consent (if participant is under 18 years of age):
I am the parent or guardian of the minor named above and have the legal authority to execute the above release. I agree to the terms of the above release.

Parent/Guardian Name (print)	Parent/Guardian Signature	Parent/Guardian Phone #	Today's Date

Mephibosheth Ministries, Inc. is the responsible party collecting this form for Camp Mephibosheth .
1715 Stringtown Pike, Cicero, IN 46034 or fax 317-984-3351

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant _____ DOB: _____ Height _____ Weight _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medication: _____
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: + -
Neurological Symptoms of AtlantoAxial Instability: _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			
Other			
Other			
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 (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____

Please take notice of the back side of this form.

Deciding to accept a client into our operating center's therapeutic riding program is an important step. Effective decision-making depends on several factors. It is necessary to determine whether precautions will limit or contraindications will prevent a client from participating in our program. The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic	Neurological	Medical/Surgical
Spinal Fusion	Hydrocephalus/shunt	Allergies
Spinal Instabilities/Abnormalities	Spina Bifida	Cancer
Atlantoaxial Instabilities	Tethered Cord	Poor Endurance
Scoliosis	Cjoaro II Malformation	Recent Surgery
Kyphosis	Hydromyelia	Diabetes
Lordosis	Paralysis due to Spinal Cord Injury	Peripheral Vascular Disease
Hip Subluxation and Dislocation	Seizure Disorders	Varicose Veins
Osteoporosis		Hemophilia
Pathologic Practures	**Secondary Concerns**	Hypertension
Coxas Arthrosis	Behavior problems	Serious Heart Condition
Heterotopic Ossification	Age under two years	Stroke (Cerebrovascular-Accident)
Osteogenesis Imperfecta	Age two-four years	
Cranial Deficits	Acute exacerbation of chronic disorder	
Spinal Orthoses	Indwelling catheter	
Internal Spinal Stabilization Devices		

Thank you for your time and consideration. Please feel free to contact us if we can assist you in any way.

Sincerely,

HoofPrints Staff