

2024 Kids Across America (KAA) KALEO HEALTH FORM Camp _____ Session _____

Group Name _____ Group Leader _____ Cell # _____

Kaleo Name _____ **Gender** M F Age at Camp _____ Birth date _____
(circle one) month/day/year

Address _____ **Kaleo email:** _____
Street City State Zip Code

Kaleo Phone _____ **Ethnic Background** African American Caucasian Latino Other _____ T-Shirt Size _____

Emergency Contact Name: _____ Cell/Home Phone (____) _____ Work (____) _____

KAA reserves the right to refuse enrollment to, or to dismiss an individual from the program whose mental, physical, psychological, or emotional condition, is outside the parameters of camp or who may be potentially detrimental to their own safety, or to the safety of others. Due to the mission of KAA, any person with a condition including, but not limited to, those referenced in the Camper/Kaleo Eligibility Restrictions (see page 4) cannot enroll or participate in KAA programs. Individuals identified as having any of these conditions are sent home at your expense.

√ if YES for the following: ___ Covid-19 Vaccine Dates: _____

Medication Allergies: ___ Amoxicillin ___ Bactrim/Septra/Sulfa ___ Cephalexin/Keflex ___ Penicillin ___ Ibuprofen, Motrin, Advil ___ Tylenol ___ Latex

Medication Allergy Explain: _____

Food Allergies: ___ Peanuts and/or nuts ___ Other food allergy _____ EpiPen prescribed ___

Explain food allergy/reaction: _____

KAA does not make exceptions or offer alternatives for food allergies or personal dietary needs.

Environmental Allergies: ___ Insect stings/bites ___ Poison ivy, poison oak or sumac ___ Other environmental allergy _____

Explain allergy and reaction: _____ EpiPen prescribed

Health History: √ if YES for the following:

___ Injury/illness requiring the use of a shunt ___ Pain, dizziness during or after exercise ___ Severe Anger/Anxiety/Depression/Bipolar ___ Migraines

___ Visual Impairment or Hearing Impairment ___ Physical Disability (muscular/coordination), Paralysis, Extreme Obesity

___ Orthopedic Problems (knee, ankle, shoulder, etc.) ___ Bleeding Disorder ___ Organ Transplant ___ Cancer ___ Mononucleosis (date) _____

___ Celiac Disease / GI Disorders ___ Severe Asthma (must send inhalers) **Submit Asthma Action Plan** contact registration department

___ **DIABETES** ___ Insulin Month/year of diagnosis _____

Diabetes MUST be controlled and regulated with date of original diagnosis more than **6 months** from arrival date at camp.

___ I acknowledge I have read and understand and agree to the Diabetic Policy which I will submit to the Health Director at least 1 month prior to camp for registration approval.

___ **SEIZURES** Month/ year of diagnoses _____

Kaleos newly diagnosed or with seizure activity in the past 6 months are NOT eligible to attend camp.

___ I agree to submit the Seizure Questionnaire to the Health Director at least 1 month prior to camp arrival for registration approval.

___ Has individual been hospitalized in the past year? _____

___ Activities individual is restricted from doing? What/why _____

Social Concerns: ___ Depression ___ Panic disorder ___ Suicidal thoughts/attempts ___ Self Harming ___ Drug abuse

___ Alcohol abuse ___ Tourette Syndrome ___ Bipolar disorder ___ Sexual Abuse ___ Other

Additional information _____

****We require that all Kaleos who attend KAA have adequate medical coverage. Please complete the information below.**

Insurance Carrier Name _____ Phone (____) _____

Type: ___ Ministry ___ Individual ___ Medicaid (requires SSN: _____) Ins. Policy # _____ Co-Pay \$ _____

If the Kaleo is covered under the ministry's group insurance, the Group Leader must supply a copy of the ministry's "Plan of Service" policy prior to arrival.

Name _____ Gender M / F Group Name _____

KALEO COMMITMENT

We hope that Kids Across America (hereafter “KAA”) is a time of refreshment, growth, and a challenge for all. We believe that these responsibilities and guidelines will assist you during your time with us! Please read each commitment and sign below.

Kaleos are responsible for their own medical care. If there are any health conditions that need further explanation, the Kaleo will discuss the health concern with the Health Staff.

- I understand and agree with the KAA policy that Kaleos must be at least 20 yrs. old. I also confirm that I am at least 20 yrs. old or will be by the date of my session.
- I understand and agree that I am required to abide by all rules listed in the Kaleo Playbook which is distributed at KAA.
- I will attend the **MANDATORY MEETINGS** each morning at the Payne Stewart Memorial training center **ON TIME**.
- I understand and agree to be prepared to have Bible Study, and discussions for 40 minutes every other morning during Harambee (group meetings) with my campers. Each camp has Harambee simultaneously; there must be a Kaleo at each camp who is prepared to meet with my campers during this time.
- The KAA staff is trained to work with my campers; enabling me to participate in Kaleo programming throughout the week. I understand and agree that Free Time and evening programs are an opportunity to spend time with my campers and I may choose to spend this time with them.
- I understand and agree that I need to be in decent physical condition and be able to easily do all the walking one would expect in an athletic camp experience. I should expect to participate in physical activities like those of my campers such as treetops, water activities.
- I understand and agree that I am given the opportunity to participate in a Bible Study and round table discussions with fellow inner city youth leaders around the country.
- I understand I am asked to volunteer in the KAA dining hall or other service project at least once during my session.
- I agree that neither I nor my group leader will change my camp assignment without the consent of the Registration Staff.
- I understand and agree that while I may bring laptops, tablets and cell phones or other electronic devices to camp; use of these is limited and KAA is not to be held responsible for lost, stolen or damaged items.
- I agree to bring all required, prescribed medications such as insulin, inhalers, epi-pens etc. for myself **in the original containers** and in quantities to cover the entire camp stay. I am responsible for keeping my own medications contained and taking them as prescribed or as indicated on the manufacturer’s label.

Covid-19 Advisement! Kids Across America has established necessary protocols to lessen the risk of COVID-19 exposure. An inherent risk of exposure to COVID-19 exists in any public place. By visiting Kids Across America Kamp, you voluntarily assume all risks related to exposure to COVID-19.

I have fully read, understand and agree to the conditions stated herein:

Kaleo’s Signature

Print Name

____/____/____
Date

Name _____ Gender M / F Group Name _____

Kaleo Release, Waiver and Authorization

I realize the use of Kids Across America (hereafter, "KAA" or the Program) facilities may involve risks with which I may be unfamiliar and that I assume this risk on my own behalf.

1. I and all respective heirs, agree to and do hereby release, indemnify and hold harmless KAA, and its respective officers, directors, associates, employees and agents from and against any and all liability, claims, damages, demands, causes of action and judgments, including but not limited to those relating to personal injury and damage to or loss of property that arise from or relate to the individual's use of KAA'S facilities and participation in activities and events at KAA's on-site facilities and KAA off-site sponsored events. This release and hold harmless applies to losses based on tort, privacy interests, and otherwise whether now known or that may arise in the future.
2. I understand and confirm that my participation in the Program is voluntary.
3. I understand that all camping and recreational programs carry with them significant risks.
4. I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with my participation in the Program. I accept personal responsibility for any liability, injury, loss, or damage to persons or property in any way connected with my participation in the Program.
5. I understand that photographs and video footage taken of me as a result of participation in the Program may be used in KAA materials, publications and/or posted to the internet. By signature below, I waive any right that I may have to inspect or to approve the materials that KAA may choose to publish.
6. I recognize the religious nature of KAA and agree that KAA has the right to dismiss me for any conduct that stands in contradiction to KAA stated beliefs, policies, and mission. I understand that such conduct would impede and burden the integrity and religious mission of KAA as well as interfere with the religious experience of other attendees and staff. I submit to the designated authority of KAA to resolve any disputes relating to attendees policies and practices. I understand that, should I be dismissed, no tuition refund will be made and that I will be liable for any expenses incurred by myself or by KAA related to such dismissal (i.e., transportation, lodging, etc.).
7. The agreement is governed, construed, and enforced in accordance with the laws of the State of Missouri. All actions shall be brought and maintained in the courts located in Taney County, Missouri, and I hereby waive all objections to jurisdiction and venue therein.
8. In the event of an incident requiring emergency medical attention, I hereby authorize the Program to seek medical attention on my behalf using the services selected by KAA staff to transport, hospitalize, secure proper treatment for, and/or to order injection and/or anesthesia and/or surgery as required. I also authorize KAA 's health staff to evaluate and treat me as medically necessary, including the administration of COVID-19 test.
9. The information I have provided on this application is true and complete to the best of my knowledge. Any falsification, misrepresentation or omission of any fact in my health form or other materials, can be justification for refusal of Kaleo services, or termination from Kaleo services for KAA.

THIS IS A RELEASE OF LIABILITY, WAIVER, INDEMNIFICATION, AND CONSENT. I HAVE READ THIS RELEASE OF LIABILITY, WAIVER, INDEMNIFICATION, AND CONSENT. I UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS AND MY RIGHTS BY SIGNING IT. I AM SIGNING THIS RELEASE OF LIABILITY, WAIVER, INDEMNIFICATION, AND CONSENT VOLUNTARILY.

This signature represents the person ultimately responsible for this registration and who is registered under this account. I have fully read, understand and agree to the contents of this application including the Attendee Eligibility Restrictions.

Kaleo's Signature

Print Name

____/____/____
Date

2024 Kids Across America (KAA) Health Form

Please ✓ the correct Camp:

____ KAA 1 ages 10-12 ____ KAA 2 ages 13-14 ____ KAA 3 ages 15-18

Circle correct Session – choose only ONE

Session 1 Session 2 Session 3 Session 4 Session 5

Session 6 Session 7 Session 8 Session 9

Higher Ground ages 14 – 18
Choose correct Camp and Session:

____ HG1 Session 2

____ HG1 Session 5

____ HG1 Session 8

____ HG2 Session 3-4

____ HG2 Session 6-7

____ HG3 Session 9

HG camper will also attend KAA2 or 3?
Yes / No If so, which Session? ____

Will use the Transitional Program?
Yes / No

Group Name /Family Name _____

Group Leader _____ Cell # _____

Parent Name _____ Cell # _____ Parents Email: _____

Camper Name: First: _____ Last: _____ Gender: (circle one) M / F

DOB: _____ Age at Camp: _____ Ethnicity: __ African American/ Black __ Caucasian __ Latino __ Other T-shirt Size _____

Emergency Contact: _____ Whom does the Camper live with __ Both Parents __ Mother __ Father __ Other _____

Mother/Guardian _____ Cell Phone () _____ Work () _____

Father/Guardian _____ Cell Phone () _____ Work () _____

Full Address: _____

Street

City

State

Zip

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✓ if YES for the following: __ Covid-19 Vaccine Dates: _____

Medication Allergies: __ Amoxicillin __ Bactrim/Septra/Sulfa __ Cephalexin/Keflex __ Penicillin __ Ibuprofen, Motrin, Advil __ Tylenol __ Latex

Medication Allergy Explain: _____

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Explain food allergy/reaction: _____

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Environmental Allergies: __ Insect stings/bites __ Poison ivy, poison oak or sumac __ Other environmental allergy _____

Explain allergy and reaction: _____ EpiPen prescribed

Health History: Immunization Record or Physicians Note required.

✓ if YES for the following: __ Injury/illness requiring the use of a shunt __ Pain, dizziness during or after exercise

____ Severe Anger/Anxiety/Depression/Bipolar __ Migraines

____ Visual Impairment or Hearing Impairment __ Physical Disability (muscular/coordination), Paralysis, Extreme Obesity

____ Orthopedic Problems (knee, ankle, shoulder, etc.) __ Bleeding Disorder __ Organ Transplant __ Cancer __ Mononucleosis (date) _____

____ Celiac Disease / GI Disorders __ Severe Asthma (must send inhalers) **Submit Asthma Action Plan** contact registration department.

____ Has individual been hospitalized in the past year? _____

____ Activities individual is restricted from doing? What/why _____

Camper Name _____ Gender **M / F** Age at Camp _____ Birth date _____

√ if Yes for the following:

___ **DIABETES** ___ Insulin ___ Month/year of diagnoses _____

Diabetes cannot be 12 and under. MUST be controlled and regulated with date of original diagnosis more than **6 months** from arrival date at camp.

___ I acknowledge I have read and understand and agree to the Diabetic Policy which I will submit to the Health Director at least 1 month prior to camp arrival for registration approval.

___ **SEIZURES** ___ Month/ year of diagnoses _____

Campers newly diagnosed or with seizure activity in the past 6 months are NOT eligible to attend Kamp.

___ I agree to submit the Seizure Questionnaire to the Health Director at least 1 month prior to camp arrival for registration approval.

Social Concerns: √ if Yes for the following: ___ Depression ___ Panic disorder ___ Suicidal thoughts/attempts ___ Self Harming
 ___ Drug abuse ___ Alcohol abuse ___ Tourette Syndrome ___ Bipolar disorder ___ Sexual Abuse ___ Other _____

Additional information _____

Camper's primary physician's name _____ Phone () _____ Year of last Tetanus shot: _____

All medication, medical equipment and supplies must be labeled with Campers name and usage information.

* SCHEDULED MEDICATIONS List each medication, frequency B,L,D or HS/hour of sleep. <u>Prescriptions must be in the original pharmacy container</u> with child's name and current prescription. ONLY send enough medication for 6 days plus 1-2 extra for the trip to and from Kamp. Pack each child's medication separately from the other group members. Place the signed signature page from this health form in a zip lock bag with the medication and give to the group leader.	Time of Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
		/	/	/	/	/	/
	B						
	L						
	D						
	HS						
	B						
	L						
	D						
	HS						
	B						
	L						
	D						
	HS						

****We require that all Campers who attend KAA have adequate medical coverage. Please complete the information below.**

Insurance Carrier Name _____ Phone () _____

Type: ___ Ministry ___ Individual ___ Medicaid (requires SSN: _____) Ins. Policy # _____

Co-Pay \$ _____ *If camper is covered under the ministry's group insurance, the Group Leader must supply a copy of the ministry's group insurance coverage "Plan of Service" prior to arrival.*

Camper Name _____ Gender M / F Age at Camp _____ Birth date _____

Parent/Guardian Release, Waiver and Authorization

In exchange for my child being allowed to participate in the Kids Across America Program (the "Program"), we, the parent(s) or legal guardian(s) (individually and collectively referred to below in the first person singular) of the child identified on this Application agree to be bound by each of the following:

1. I understand and confirm that our child's participation in the Program is voluntary.
2. I understand that all camping and recreational programs carry with them significant risks.
3. I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with my child's participation in the Program. I accept personal responsibility for any liability, injury, loss, or damage to persons or property in any way connected with my child's participation in the Program.
4. I and all respective heirs, agree to and do hereby release, indemnify and hold harmless KAA, and its respective officers, directors, associates, employees and agents from and against any and all liability, claims, damages, demands, causes of action and judgments, including but not limited to those relating to personal injury and damage to or loss of property that arise from or relate to the individual's use of KAA facilities and participation in activities and events at KAA's on-site facilities and KAA off-site sponsored events. This release and hold harmless applies to losses based on tort, privacy interests, and otherwise whether now known or that may arise in the future.
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7. The agreement shall be governed, construed, and enforced in accordance with the laws of the State of Missouri. All actions shall be brought and maintained in the courts located in Taney County, Missouri, and I hereby waive all objections to jurisdiction and venue therein.
8. In the event of an incident requiring emergency medical attention, I hereby authorize the Program to seek medical attention on my child's behalf using the services selected by Program to transport, hospitalize, secure proper treatment for, and/or to order injection and/or anesthesia and/or surgery as required. I also authorize Program's health staff to administer prescribed medications, to evaluate and treat my child as medically necessary, including the administration of COVID-19 test.
9. Information provided on this application is true and complete to the best of my knowledge. Any falsification, misrepresentation, or omission of any fact in my child's health form or other materials, can be justification for refusal or termination from camper services. **I have read the Attendee Eligibility Restrictions.**

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If my child is attending Higher Ground, I consent for KAA/Higher Ground to take my child off campgrounds for the purpose of participation in a local service project, regional mission trip or International Missions which will require travel to countries outside the United States.

I have fully read, understand and agree to the conditions stated herein:

 Parent or Guardian Signature

Print Name

Date

2024 Kids Across America Attendee Eligibility Restrictions

Individuals with the following cannot attend KAA Kamps:

- Pregnancy
- Sickle Cell
- Vision/Hearing impaired
- Uses Wheelchair/Paralysis
- Requires assistance to walk dress, eat, bathe, use toilet facilities, etc.
- Takes more than 2 psychotropic drugs (medication designed to alter the mind, emotions, and/or behavior)
- Unregulated Asthma or diagnosed within 12 months of camp start date
- Diabetes ages 10-12, Unregulated Diabetes or diagnosed within 6 months of camp start date
- Seizure activity within 6 months of camp start date
- Hemophilia/Communicable disease/Immune Deficiency
- Cognitive delays, Autism, Down Syndrome, Developmental Disability
- Responds defiantly to correction
- No hard casts
- Those unapproved by the Registration Team

*Participants must be in general good health and able to participate in the required walking and athletic activities typical of our camp.

*KAA does not restrict the attendance of those who are juvenile delinquents/wards of the state. However, individuals must respond positively to authority & participate in camp activities.

*Regulated diabetics MUST be cleared through the Health Services Director BEFORE attending.

*Inhalers are primarily kept by the campers and the counselors or the Health Center as needed as a secondary measure.

Camp Barnabas specializes in camping for individuals with physical and/or developmental disabilities and their families. Their offices may be reached at 417-476-2565 or www.campbarnabas.org.

If a condition is not listed, it does not mean that it is permitted. If you question eligibility, please contact the Registration Team at 417-266-4000.

2024 Kids Across America Attendee Eligibility Restrictions

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- **Sickle Cell**
- **Vision/Hearing impaired**
- **Uses Wheelchair/Paralysis**
- **Requires assistance to walk, dress, eat, bathe, use toilet facilities, etc.**
- **Takes more than 2 psychotropic drugs (medication designed to alter the mind, emotions, and/or behavior)**
- **Unregulated Asthma or diagnosed within 12 months of camp start date**
- **Unregulated Diabetes or diagnosed within 6 months of camp start date, Diabetes ages 10-12.**
- **Seizure activity within 6 months of camp start date**
- **Hemophilia/Communicable disease/Immune Deficiency**
- **Cognitive delays, Autism, Down Syndrome, Developmental Disability**
- **Responds defiantly to correction**
- **No hard casts**
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