train youth
grow community
steward creation

910-247-0062
2765 River Road SE,
Winnabow, NC 28479
fun@onelife.org

EXPEDITION APPLICATION

Please print and mail or scan and email application to OneLife.

Expedition Choice: ______________________________
(Age Bracket and Date)

PARTICIPANT'S NAME: ______________________________
Last First Mi.

Phone: ______________________________
MAILING ADDRESS:
CITY: ____________________ STATE______ zip ____________
☐Male ☐Female Birth Date: ____________ Age: _____ Grade this fall: ________

PARENT/LEGAL GUARDIAN INFORMATION:
Name :____________________________ Phone: ____________
Place of Employment: ______________________________
Email Address: ______________________________

The following persons are authorized to pick up ____________________ (participant) from OneLife.
Name: ______________________ Phone: ______________ Relationship: ____________
Name: ______________________ Phone: ______________ Relationship: ____________

Release Authorization:
I am the applicant's legal guardian and by signing below, I give permission for the above people to pick up my child. (Please note that we will not release the participant to anyone other than the Parent/Legal Guardian without this signed release authorization. No exceptions.

____
Parent's Signature and Date:

Photography Waiver:
Camp participants may be photographed or videoed for future promotional and/or informational materials regarding OneLife. Please sign below if you consent to your young adult being photographed and/or videoed. **PLEASE CONTACT OUR OFFICE TO BE ADDED TO THE "DO NOT PHOTOGRAPH" LIST IF YOU DO NOT WISH TO SIGN THIS WAIVER.**
Parent's Signature and Date: ______________________________

PARTICIPANT CODE OF CONDUCT

Parents: The following are OneLife's behavior expectations for participants during Expedition. Please read through the Code of Conduct with your child before camp starts. Please check each one.

While participating at camp, I agree to:
Please check each in agreement.
___ Stay with my leader and group at all times
___ Be a responsible member of the community
___ Think in advance about the consequences of my actions
___ Be considerate & respectful of others' feelings & needs
___ Resolve differences in a respectful manner
___ Assure my own and others' safety
___ Protect the natural environment
___ Commit to honesty
___ Commit to fully participate
___ Follow all guidelines set by group leaders

Our Approach to Behavior Management will be:
1. Verbally warn the participant of behavior that is inappropriate.
2. Remove participant from group for a period of time with encouragement to improve.
3. Give dismissal warning if behavior does not improve.
4. Dismissal for the rest of camp.

Participant Signature:

____

Participant Name:

Participants - Please tell us about yourself and what you're looking forward to while at camp: ☺

PARTICIPANT HEALTH HISTORY FORM

Participant's Name ____
Last First M.I.

PARENT/GUARDIAN AUTHORIZATION & CONSENT TO TREAT
If for any reason you wish not to authorize treatment, please attach a letter of explanation.

I attest that my child (participant's name) ____________________________ is in good health and able to actively participate in OneLife activities except as noted in this form. I take full responsibility to see that my child is properly prepared for camp including having proper clothes and equipment and being in good health.

I authorize OneLife to provide routine health care, administer prescribed and over-the-counter medications that I am sending to OneLife, as well as any medications recommended by OneLife's health care staff for various problems except as I have noted in this form. I authorize OneLife to share information on this Health History document with selected staff (counselor, health care, inclusion staff, etc.) and professional health care providers on a need-to-know basis.

In case of medical emergency or need for medical treatment, after every reasonable effort has been made to contact me, the family physician or one of the alternates listed on this form or my child's Application form, I hereby give my permission to the physician secured by OneLIfe to hospitalize, secure treatment for and order injection, anesthesia or surgery for my child named above. I authorize OneLife to arrange and/or provide necessary related transportation for my child. I authorize OneLife to secure copies of the child's health record when/if the child is seen by an off campus health care provider (e.g. MD at the local clinic, DDS). I agree to be responsible for expenses incurred in the care and treatment of my child.

I release OneLife, all staff, counselors, directors, and affiliated personnel of any liability for accidents incurred on or off of OneLife property. I will notify OneLife Staff of any recent illnesses, fever, or health status changes upon my participant's arrival to OneLife. There are no medical doctors on-site at OneLife. The OneLife staff utilizes medical oversight and collaboration from off-campus doctors and/or the participant's private health care provider.

→Signature of Parent/Legal Guardian: ____

Print Name: ____________________________ Date: ____________________

INSURANCE INFORMATION	
Insurance Company	
Policy Number	
Group Number	
Name of Primary Insured Person	
Relationship to Participant	
Social Security # of Policy Holder / Insurance I.D. #:	
Participant's Primary Physician	Name:
	Address:
	Phone:

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian with legal custody to be contacted in case of emergency:	
Name:	
Relationship to Participant:	

Participant Name:

Home:	
Work:	
Cell:	

Second parent/guardian to contact:	
Name:	
Relationship to Participant:	
Home:	
Work:	
Cell:	

Additional contacts in event parents cannot be reached:	
Name:	
Relationship to Participant:	
Home:	
Work:	
Cell:	

Is there anyone in particular to whom your child must NOT be released?	
Name:	
Relationship to Participant:	

ALLERGIES Please list all known allergies, including reaction and treatment to be given. We ask that those who knowingly have a severe allergic reaction please bring along their Epi-pens.

Type of Allergy	List All	Type of Reactions (swelling, rash, vomiting, headaches, behavior, etc.)
Medication (penicillin, sulfa, etc.)		
Food (peanut butter, cheese, milk, eggs, etc.)		
Environmental/Seasonal (stings, poison ivy, hay fever, etc.)		
Other		

IMMUNIZATION HISTORY

Please Check for Exemptions: ☐Medical ☐Religious/Philosophical

Please give ONLY the most recent dates. Last tetanus booster is very important.

Vaccine	Date		Vaccine	Date
DTP (DTPH/DTaP) Series			**Polio OPV (IPV)**	
DTP Booster (Tetanus Booster)			**Polio Booster**	
Pneumococcal			**Varicella (initial if had chicken pox)**	
Mumps, Measles, Rubella (MMR)			**Hepatitis B series**	

Have you been in countries other than the U.S. in the past year? . . . . ☐Yes ☐No

Country:______________________________ Dates :______________________________
Country:______________________________ Dates :______________________________
Country:______________________________ Dates :______________________________

Participant Name:

DIET and NUTRITION

Please circle all that apply, and give any specifics that will help the staff provide the best possible nutritional support for your child.

- Participant eats a normal diet
- Vegetarian
- Lactose Intolerant/dairy-free
- Gluten Intolerant/wheat-free
- Vegan
- PKU
- Other *(specify)*:

MEDICAL HISTORY, SURGERY, and HOSPITALIZATION

Please list all past medical problems and chronic health problems, including newborn conditions/illnesses and any medical problems that have been corrected. These are very important to the medical staff when treating participants. All information is kept strictly confidential and will only be shared on a need-to-know basis. (Ex: asthma, diabetes, ADHD)

Does the participant have a history of any of the following? Check all that apply:

- Asthma
- Bed wetting
- Back or Joint (knees, ankles, etc) problems
- Chronic Illness or Reoccurring Illness/Condition
- Chest pain during or after exercise?
- Diabetes
- Dizziness/Passing Out (at any time, including during or after exercise)
- Ear Infections
- Head Injury/ Been Knocked Unconscious
- Heart problems and/or Murmers
- Low or High Blood Pressure
- Hospitalizations and/or Surgery
- Nightmares
- Frequent Headaches
- Migraines
- Mononucleosis
- Physical disabilities
- Recent injuries , illness, or infectious disease
- Seizures
- Sleepwalking
- Skin Problems (e.g., itching, rash, acne)
- Specific Fears/Phobias
- Wears Glasses, Contacts, etc
- Other *(specify)*:

Any restrictions on the participant's activity while on Expedition? If yes, please explain: ☐No ☐Yes

____

____

Please explain any checked items:

MENTAL & EMOTIONAL HEALTH

Has the participant been diagnosed or treated for any of the following? This is not to label the child, but to assist in helping them to have a great experience.

- ADD
- ADHD
- Anxiety
- Autism/Spectrum
- Depression
- Developmental disabilities
- Eating disorder
- Learning disability
- OCD
- ODD
- PTSD
- Other psychiatric diagnosis *(specify)*:

Please explain any checked items:

Any home, family or other life experiences or circumstances that staff should know about? Please explain:

____

Any Other Medical Instructions/Procedures* (diabetic care, emergency instructions, etc.)

____

*All chronic medical conditions and any medical procedures that are needed during the participant's stay should be addressed with the OneLife staff before the start of expedition.

ANYTHING ELSE?

Is there anything else we should know about your child?

____

Participant Name:

MEDICATIONS List ALL medication the participant is bringing to OneLife, including vitamins, prescriptions and ov*er-the-counter meds. Bring enough medication to last the entire time at OneLife. The First Aid Kit is stocked with over*-the-counter meds for an as-needed basis. If your child takes an over-the-counter on a daily/regular basis (ie: Claritin for season allergies) please send those with your child. All medication must have:

- Original pharmacy or manufacturer containers
- Child's name (meds belonging to a sibling or other family member are not accepted)
- Current date (expired meds are not accepted)
- Written directions from pharmacy or physician (parent instructions for prescription medications are not accepted)

SELECT ONE:

This person takes NO medications on a routine basis.
This person takes medication(s) as follows:

Name of medication	Reason for taking	Amount or dose given	When given	How it is given (with food, etc)	Self-Administration (circle)
			☐Breakfast ☐Lunch ☐4 p.m. ☐Dinner ☐8 p.m.		YES NO
			☐Breakfast ☐Lunch ☐4 p.m. ☐Dinner ☐8 p.m.		YES NO
			☐Breakfast ☐Lunch ☐4 p.m. ☐Dinner ☐8 p.m.		YES NO
			☐Breakfast ☐Lunch ☐4 p.m. ☐Dinner ☐8 p.m.		YES NO
			☐Breakfast ☐Lunch ☐4 p.m. ☐Dinner ☐8 p.m.		YES NO

The following medications (or their generic equivalents) may be stocked in the Medical Lock Box and field first aid kit and administered as needed. Cross out any medications that the participant should not be given:

Acetaminophen [Tylenol]
Aloe Vera
Altoids/peppermint
Antibiotic Ointment
Athlete's Foot
Ointment/Powder
Baking Soda/Meat Tenderizer
Benadryl
Calamine or Caladryl Lotion
Chloraseptic Spray
Chlor-Trimeton
Cholacol (activated charcoal)

Cough Drops/Throat Lozenges
Epinephrine (Epi-pen for life threatening emergencies only)
Excedrin
Gatorade
Gold Bond Medicated Powder
Herbal tea
Hydrocortisone
Ibuprofen [Advil]

Insect Repellant
with or without Deet

Kaopectate
Lice Shampoo
Lidocaine Jelly
Loratadine (Claritin)
Milk of Magnesia
Pepto Bismol
Robitussin
Skin Moisturizer
Sudafed
Sunscreen
Tums
Visine Eye Drops

Participant Name:

Participants are authorized to self medicate/self-carry if the authorization (below) has been signed AND the medication is not a controlled substance. Elementary participants are NOT allowed to self-medicate any type medication that is taken by mouth, with the exception of inhalers.

Self Administration/Self-Carry Authorization: I authorize and recommend self-medication and/or self-carry by my child for their prescribed and over-the-counter medications (with the exception of controlled substances). I also affirm that he/she has been instructed in the proper self-administration and/or self-carry of the prescribed medication by his/her health care provider. I shall indemnify and hold harmless OneLife and all employees and volunteers of OneLife against any claims that may arise relating to my child's self-administration and/or self-carry of prescribed medications and over-the-counter medications.

→**Parent Signature**: ______________________________________**Date**: ______________________

(optional) MEDICAL EXAMINATION We recommend, but do not require, that participants have a medical exam & physician's authorization within the last 24 months prior to camp. A copy of a school/sports physical exam is also acceptable.

Physician's statement - I find the participant to be in good health and able to take part in outdoor activities at OneLife with the following exceptions:

____

____

Physician's signature: ______________________________________ Date of exam: __________________

Print Name: ______________________________________ Phone: (_______) ________________________

OneLife Medication Guidelines -- Please Read Carefully

A written order by a doctor and the consent of a parent/guardian is required for ANY medical procedure (with the exception of first aid). This includes diabetes care, wound care, and any specialized medical care.

1. ALL medications must be hand delivered by a parent/guardian or responsible adult to the OneLife staff or nurse during check-in. DO NOT PACK MEDICATIONS in the participant's luggage. This includes ALL participants who Self-Administer and/or Self-Carry medications. The OneLife nurse must verify all orders, signatures and forms BEFORE participants are allowed to carry and self-administer their medications.

2. All controlled substances **MUST** be kept in the OneLife Field Lock Box. Participants are NOT allowed to keep controlled substances.

3. The first dose of any **NEW** medication should **NOT** be given at OneLife.

4. **ALL** participants with a prescription (Rx) medication **MUST** have a current pharmacy prescription label attached to the original container. When a participant has a sample from a doctor, the doctor **MUST** write a prescription label by hand and attach to the sample medication. Any prescription label that states, **"Use as Directed"** is not acceptable per state guidelines. Directions **MUST** be specified.

5.Re-packaging of medications is not acceptable (such as placing in a pill box or other container). Nurses are only authorized to administer medications directly from the original container or prescription bottle. This is the law.

6. ALL prescription (Rx) medications must:
- be in the original container with a current pharmacy prescription label attached ("Use as Directed" is not acceptable)
- have the correct participant's name on the prescription label
- have a valid date of expiration – Expired medications will NOT be accepted or administered
- not be mixed with any other medications (unless indicated on the label)

7. **ALL non-prescription (OTC)** medications (including vitamins) must:
- be new and unopened/sealed in the original container
- have no other medications mixed inside the container

Participant Name:

- have a valid date of expiration - Expired medications will NOT be accepted or administered
- have the participant's name clearly marked on the bottle

8. **ALL** participants with **INHALERS** must have a copy of the prescription label attached to the inhaler (or have a copy of the Rx label with the inhaler or original Rx labeled box). The pharmacy can print a duplicate label and can apply it to the inhaler. This is especially helpful for participants who carry their inhalers and self-medicate.

9. **ALL** participants with **EPI-PENS, TWINJECTS**, and other pre-filled single use epinephrine auto injectors must have a copy of the original pharmacy prescription label attached to the cartridge holder or be contained in the original Rx labeled box. **"Use as Directed"** is not acceptable per state guidelines. Directions **MUST** be specified.

I have read the OneLife Medication Guidelines and understand what is required.

____

Parent's Signature and Date

Participant Name: