2025 Ceta Canyon New Dawn Camper Registration Form

2025 New Dawn

June 2-6, 2025
Mentally Challenged Adults

Mail to: Camp Registrar
37201 FM 1721
Happy, Texas 79042

Phone: 806-488-2268
Email: info@cetacanyon.org

Website: cetacanyon.org
Fax: 806-488-2594

A SPECIAL PLACE WHERE GOD IS EXPERIENCED AND LIVES ARE CHANGED.

For Office Use Only

Check # _____ $ _____ $ _____
Amount This camper

Check/CC From: _____

Check # _____ $ _____ $ _____
Amount This camper

Check/CC From: _____

$425 if registered before April 13, 2025 **$445.00 if registered after April 13, 2025**

Registration Forms MUST be ***completed in full*** and ***signed*** by the parent/guardian. The registration fee ***MUST*** accompany the Registration Form, or camper will be placed on the "waiting list" until full payment is received.

Please Print Legibly ***Please Print Legibly*** ***Please Print Legibly***

Camper Name _____
Last Middle Initial First Goes By

Home Address _____
Street or PO Box Number City State Zip

Home Phone # (____) _____ Cell # (_____) _____ Camper Email _____

Does camper reside at (please check one): Home _____ Foster Home _____ Group Home _____

Gender: M / F Age at Camp: _____ Birth Date _____

Custodial Parent/Guardian (1) _____ Email _____

Address _____
Street or PO Box Number City State Zip

Home Phone# (_____) _____ Work Phone# (_____) _____ Cell Phone#(_____) _____

Custodial Parent/Guardian (2) _____ Email _____

Address _____
Street or PO Box Number (If different than Parent 1) City State Zip

Home Phone# (_____) _____ Work Phone# (_____) _____ Cell Phone#(_____) _____

Alternate **Emergency Contact** _____ **Relationship** _____ **Phone # (____)** _____

Home Church _____ City _____ Phone# (____) _____

Who will pick up camper after camp? _____

Roommate Preference (1 **only** please) _____
(Roommate preference not guaranteed. Roommate preference not available for campers registered onsite.)

Ceta Canyon receives grants from various foundations to improve programs and facilities of the camp. Many request demographic information, including ethnicity*. Please select from the following:

- ☐ Caucasian
- ☐ Hispanic
- ☐ African American
- ☐ Other (Native American, Asian, etc.)

**Note:* NO personal information is disclosed.*

If you are interested in donating a Scholarship for a Camper, contact the Ceta Canyon Office.

CAMP NEW DAWN I HEALTH EXAMINATION FORM

Please have parent/guardian and physician complete appropriate sections of this form **in full** before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. **Everything must be completely filled out or form will be returned.**

Camper Name: _____ **Date:** _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

***This section must be filled out before form is considered complete.**

Self Care:

Can the camper shower self alone? ____ Yes ___No Explain _____

Can the camper brush teeth? _____Yes _____No Explain _____

Can the camper wash hands before meals? _____Yes _____No Explain _____

Is the camper completely toilet trained? _____Yes _____No Explain _____

Wipes self? _____Yes _____No Explain _____

Is camper able to dress self? ____ Yes _____No Explain _____

Does camper wet the bed? ____ Yes __No Explain Does _____

Does camper have incontinence problems? ____ Yes _____No Explain _____

Does camper wear protective garments (i.e. Depends)? _____Yes _____No Explain _____

Eating Habits:

Is the camper on a special diet? ___Yes ___No Explain Does _____

Does camper need help with eating? ___Yes ___No Explain Does _____

Does camper choke easily? _____Yes _____No Explain _____

Mobility and Communication:

Is camper able to talk? ____ Yes _____No Explain _____

Is camper able to read? ____ Yes _____No Explain _____

Does camper walk well? ____ Yes _____No Explain _____

Is camper an early riser? —— Yes _____No Explain _____

Is camper a sleepwalker? ____ Yes _____No Explain _____

Restrictions on swimming, diving? ____ Yes _____No Explain _____

Restrictions on strenuous activity? ____ Yes _____No Explain _____

Does camper smoke or chew tobacco? ____ Yes _____No Explain _____

Female Campers Only:

Has camper begun menstrual periods: _____ Can camper manage without help? _____

Needs supervision? _____ Needs help? _____ Exactly what help? _____

Allergies:

Food _____

Drug _____

Other _____

Chronic Conditions: Check all that apply to your camper.

- ☐ Asthma
- ☐ Frequent ear infections
- ☐ Migraine headaches
- ☐ Bed Wetting
- ☐ Depression, ADD, ADHD, Oppositional Behavior Disorder
- ☐ Anorexia, Bulimia
- ☐ Diabetes If so, does the camper require insulin injections? ____
- ☐ Seizures If so, please describe ____
- ☐ Any other chronic illness? ____
- ☐ Does the camper ever resort to self harm such as cutting, biting, scratching, etc? If so please explain and provide any necessary information to help the camper. ____

Supportive Care: Check all that apply to your camper.

- ☐ Glasses
- ☐ Hearing Aids
- ☐ Dental Appliances
- ☐ Other special equipment? ________________________

Has the camper had any major surgeries or serious medical issues since the last time he/she attended camp? ____________

____

Is there anything else that you would like us to know about your camper that could help us make his/her experience more enjoyable? ____

____

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PARENT/GUARDIAN AUTHORIZATION: This health history is correct so far as I know and the person herein described has my permission to engage in all prescribed camp activities, except as noted by me and the examining physician. **In the event that I cannot be reached in an EMERGENCY**, I hereby give permission to the physician, selected by the camp director, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Custodial Parent/Guardian Signature: ________________________________ Date: ________________________________

Insurance Information: **Please send a front and back copy of insurance card with this form.**

If there is no insurance for the camper, please check here: ☐

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or "back-up" coverage on a limited basis to any other coverage the camper has under separate, private, or group plans.

Medical Insurance Company ____
Policy# ______________________________ Group# ______________________________
Insurance Address & Phone # ____
Family Physician Name & Phone # ____

Camp Activities at Ceta Canyon Camp may include but are not limited to: swimming, hiking in a rugged canyon setting, sports, water recreation, group games, Ropes Course and Climbing Wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental in a public camp setting and will hold the NWTX Conference, Ceta Canyon Camp and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Ceta Canyon Camp and Retreat Center to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, or on the camp's website.

Custodial Parent/ Guardian's Signature: ____________________________________ **Date**: __________________

Don't forget to include your registration fee.

Cancellation Policy: **All camp fees include a nonrefundable registration fee. A $10 handling fee will be applied to all cancellation. Ten days from the first day of camp, the cancellation fee is half of the registration fee. Cancellations within five days of the start of camp will lose their full registration fee. All cancellations must contact the camper registrar.**

How did you hear about us? Online__________________ Friend_____________ Church_____________ Postcard____________ Other___________
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Campers T-Shirt Size: S M L XL XXL XXXL

MEDICAL EXAMINATION
To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. **You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below.** Examinations are necessary for determining fitness/ability to engage in all activities.

CODE: S – Satisfactory U - Unsatisfactory (Explain) O - Not Examined

Height: _____ Weight: _____ B.P.: _____ Hgb. Test: _____ Urinalysis: _____

Eyes _____ Extremities _____

Glasses _____ Posture (spine) _____

Ears _____ Skin _____

Nose _____ Allergy - Please specify: _____

Throat _____ _____

Teeth _____ _____

Heart _____ _____

Lungs _____ General Appraisal: _____

Abdomen _____ _____

Hernia _____ _____

* (For girls and women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

_____

Comments: _____

_____

_____

_____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician Signature: _____ **Date:** _____

Address: _____ **Telephone:** (_____) _____

Camper's Name: _____ **Date Examined:** _____ **Cabin #** _____ **Year:** _____

CAMP NEW DAWN 1 CAMPER MEDICATION INFORMATION

Please complete and bring this medication form with you to camp.
This will ensure safe medication administration for your camper and a more timely registration process.

NAME OF CAMPER AS SHOWN ON PRESCRIPTION CONTAINER

_____

[ ] This camper does not take any medications on a regular basis

Note: ALL PRESCRIPTION MEDICATION MUST BE IN THEIR ORIGINAL CONTAINER SUCH AS LABELED BLISTER PACKS OR BOTTLES WITH NAMES AND DOSAGE CLEARLY MARKED ON THE CONTAINER
MEDICATIONS WILL NOT BE ACCEPTED IN PILL BOXES OR ENVELOPES NOT LABELED.

Medications will be given at breakfast, lunch, dinner and bedtime. Please list your typical routine so that we can keep the campers routine consistent.
(Please notify the nurse if a camper must have meds outside of these times)

	MEDICATION	DOSAGE	TIME
1			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
2			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
3			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
4			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
5			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
6			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
7			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
8			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
9			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
10			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
11			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
12			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime
13			[ ] breakfast [ ] lunch [ ] dinner [ ]bedtime

Allergies:
Food Allergies: _____ Medication Allergies: _____
Allergic Reaction Symptoms: _____
Treatment for reaction: _____
Is a special diet required while at camp: Yes / No Explain: _____
_____