

# 2026 Ceta Canyon New Dawn Camper Registration Form

## 2026 New Dawn

June 1-5, 2026

Mentally Challenged Adults

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



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

**\$440 if registered before April 10, 2026**

**\$460.00 if registered after April 10, 2026**

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? \_\_\_\_\_

**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			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
2			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
3			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
4			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
5			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
6			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
7			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
8			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
9			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
10			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
11			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
12			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime
13			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime

### Allergies:

Food Allergies: \_\_\_\_\_ Medication Allergies: \_\_\_\_\_

Allergic Reaction Symptoms: \_\_\_\_\_

Treatment for reaction: \_\_\_\_\_

Is a special diet required while at camp: Yes / No Explain: \_\_\_\_\_