

**Central
Pennsylvania
Youth
Ministries**

PO Box 189
Shamokin Dam 17876

David R. Hummel
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Spring 2017

Dear Summer Camper,

Just a few more days and we will be in Ocean City, NJ. Please read this letter carefully for there is a lot of information for both you and your parents.

If you need to contact our office the phone is - (570) 743-5333 or email at youthcybercenter@verizon.net

You will need money for a beach tag, we have activities scheduled for a least three days on the beach; and for some dinners and breakfasts. Lunches Monday through Thursday are provided and dinner Thursday evening is also provided. You will need spending money. Be reasonable, your parents may be glad to get rid of you for a while, but not that glad. All music devices must have ear phones. No guitars. Skateboards must be stored and used only in the skate board park on 6th St. If you bring skateboards, you must bring helmets, knee and arm pads.

Things to bring: rain gear (it may rain), beach towels, a Bible, pen, lots of clothes, a wind breaker, and suntan lotion. No linen is needed. Bring your own beach blanket or towel.

*****DO NOT BRING:** Cases of Water, there is not enough luggage space to bring along water to camp. Please bring additional money to purchase water at camp.

If you still owe money on your balance, the amount is written at the bottom of this letter. All campers must return the enclosed medical release form with it notarized and their final payment by June 1, 2017, to our office at the above address. Be sure to include your social security number on the medical form. No one is permitted to attend camp without this medical form being handed in! Remember, your registration fee is non-refundable and nontransferable. Your final payment cannot be refunded after June 1st. Failure to return your final payment by June 1st will cause you to lose the space we have reserved for you.

Your leader will be contacting you concerning time and place of departure. If you have any question about that, contact them.

We respectively ask all female campers to wear a cover-up when participating in beach activities and while attending meetings at the Ocean City Tabernacle.

Please tell your parents we have four (4) rules which are:

- 1. NO Alcohol**
- 2. NO Drugs.**
- 3. NO Co-ed Rooming.**
- 4. Cigarette Smoking and smokeless tobacco is forbidden.** If we catch you, we will take it, a second time you go home.

If you break any one of these, your parents will receive a call from you and you will be sent home. There will be no exceptions and no discussion, so **DON'T** do it!!

Balance Due \$ _____ ****PLEASE NOTE:** If you have fund raising money in your account with your club leader, this amount will differ. Please contact your club leader and find out your balance due.

Summer Camp Staff

**PERMISSION To Attend CPaYM's Camp
Summer Camp ~ June 18-23, 2017**

Name _____ School _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Grade _____ Age _____ Sex _____

HEALTH INSURANCE COMPANY: _____

GROUP NUMBER _____ POLICY NUMBER _____

I, _____ (signature), (print name) _____,
the legal parent/guardian of _____, do hereby release Central Pennsylvania
Youth Ministries from any and all liability in case of accident or illness and authorize any medical care deemed
necessary by an accredited physician, nurse or hospital while attending above mentioned function. I hereby
assume all responsibility for his/her conduct, and for any damage my teen does to the camp property or any
property of Central PA Youth Ministries, with the understanding that I will pay all damages. Any violation of
the Code of Conduct will mean that I must provide immediate transportation home for my son or daughter. The
use or possession of alcohol, illegal drugs any sexual conduct that is illegal, cigarette smoking and the use of
smokeless tobacco, a failure to refrain from inappropriate touching and any form of verbal and physical
harassment by my child will be a violation of CPAYM's code of conduct.

I permit Central PA Youth Ministries to use photographs of my child in publications and publicity material, and
for inclusion in the Central PA Youth Ministries image library.

I request the camp nurse to administer the following medications to my child while attending this camp, if I
have provided the appropriate paper work. I understand that a signed medical order form from the prescribing
doctor must accompany each prescription. (see form on back). I have attached all necessary paper work.

I request the following over the counter medications be given by the camp nurse. (check those medications your
child may receive). () acetaminophen () Tums/Roloids () Caladryl Lotion () ibuprofen () other
list _____

My child has the following allergies/medical conditions that may require emergency medication: _____

YOUR SIGNATURE MUST BE NOTARIZED. This will make it possible for us to secure medical treatment
if necessary.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____ 20 _____ (SEAL) _____

NOTARY PUBLIC

PHONE # WHERE I CAN BE REACHED _____

PLEASE SEND THIS FORM TO:
CENTRAL PENNSYLVANIA YOUTH MINISTRIES, PO BOX 189, SHAMOKIN DAM, PA 17876

Attention Parents:

The Medical Form only needs to be completed if your child has prescription medication that he/she will need to take during Summer Camp.

This form MUST be signed by the attending Health Care Provider.

**CPAYM personnel may only administer medication prescribed by a qualified health care provider.
HEALTH CARE PROVIDER'S AUTHORIZATION**

Student's Name _____

Medication 1 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Medication 2 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Medication 3 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Inhaler or Epinephrine auto injector: Student is authorized to carry and self-administer? Yes ___ No ___

Health Care Provider Signature _____

Health Care Provider print your name here _____

Date _____ Telephone No. _____

I (print parent/guardian name) _____

(signature) _____, request my child is to receive the above medication as prescribed, and I release CPAYM of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for the CPAYM Staff to communicate with the above Health Care Provider for the benefit of my child.

**CPAYM personnel may only administer medication prescribed by a qualified health care provider.
HEALTH CARE PROVIDER'S AUTHORIZATION**

Student's Name _____

Medication 1 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Medication 2 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Medication 3 _____ Dosage _____ Frequency _____

Possible Side Effects _____

Restrictions _____

Inhaler or Epinephrine auto injector: Student is authorized to carry and self-administer? Yes ___ No ___

Health Care Provider Signature _____

Health Care Provider print your name here _____

Date _____ Telephone No. _____

I (print parent/guardian name) _____

(signature) _____, request my child is to receive the above medication as prescribed, and I release CPAYM of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for the CPAYM Staff to communicate with the above Health Care Provider for the benefit of my child. not picked up at the end of the school year will be discarded