CAMPERS WILL:
• Experience chemistry as it relates to cooking in a hands-on environment
• Work with staff & faculty to learn why ingredients produce the results they do.
• Have a blast creating and EATING the “experiments”.

WWW.SBU.EDU/COOKCHEM
716-375-2045

Information & Registration
SCHOLARSHIPS ARE AVAILABLE!
WWW.SBU.EDU/COOKCHEM
716-375-2045

COOKING CHEMISTRY CAMP
(Ages 10-16)
JULY 17 TO JULY 21, 2017
8:30 AM- 4:30 PM
$205/child*
(BRING YOUR OWN LUNCH)
$245/child*
(LUNCH PROVIDED)

Kids will get creative in this camp combining cooking and chemistry!
Each day the campers will prepare several “recipes/experiments” that will unite science and cooking providing a delicious hands-on learning experience.

Of course, the best part of each day is eating the tasty food and desserts!

CAMPERS WILL:
• Experience chemistry as it relates to cooking in a hands-on environment
• Work with staff & faculty to learn why ingredients produce the results they do.
• Have a blast creating and EATING the “experiments”. 
C O O K I N G  C H E M I S T R Y  C A M P

J U L Y  1 7  T O  J U L Y  2 1 , 2 0 1 7

$205/child (*)
(BRING YOUR OWN LUNCH)

$245/CHILD* (LUNCH PROVIDED)

8:30 AM - 4:30 PM

Registration Form

Please fill out and return to the address below with your camp payment.

Section 1: Child's Information

Child's Name: ________________________________________________
First                       Last                            Nickname
Birthday:    _______/______/_____  Day/Month/Year
Address:    ______________________________________________________
Street Address
__________________________ _________    _____________
City                                                       State                    Zip Code
Phone:    (______) _______-_____________
Child's Gender:    ______ Male ______ Female

Will your child buy lunch or bring lunch?
___ Buy lunch ($40; Total camp fee=$245)
___ Bring lunch ($0; Total camp fee=$205)

May we use your child's photo in publicity materials?
______ Y es ______ No

Section 2: Parent/Guardian Information

Parent/Guardian Information 1:
Name:    _______________________________________________________
First                                                Last
Address:    ______________________________________________________
Street Address
__________________________ _________    _____________
City                                                       State                    Zip Code
Cell Phone:    (______) _______-_____________
Work Phone:    (______) _______-_____________
E-mail:    _______________________________________________________

Parent/Guardian Information 2:
Name:    _______________________________________________________
First                                                Last
Address:    ______________________________________________________
Street Address
__________________________ _________    _____________
City                                                       State                    Zip Code
Cell Phone:    (______) _______-_____________
Work Phone:    (______) _______-_____________
E-mail:    _______________________________________________________

Section 3: Physician and Insurance Information

Child's Physician:    _______________________   _____________________
First     Last
Physician's Phone:    (______) ______________-_______________________
Insurance Carrier:    ______________________________________________
Identification Number:    ___________________________________________
GroupNumber:    _________________________________________________
Name of Insured:    ________________________   _____________________
First                                     Last
Relationship to Child:    __________________________________________

Section 4: Emergency Information

Emergency Contact and Youth Pickups (if mother, father or guardian cannot
be reached):
Name:    ________________________    _____________________
First                     Last
Relationship:    ___________________________
Phone:    (______) _______-___________
Name:    ________________________    _____________________
First    Last
Relationship:    ___________________________
Phone:    (______) _______-___________

Section 5: Payment Information

Payment Amount:________________
☐ Check #________
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Card Number:________________
Name on Card:________________
Expiration Date:________________ Security Code________________
Credit Card Billing Zip Code:________________

Return this form to:
Office of Events and Conferences
St. Bonaventure University
3261 West State Road
P.O. Box 118
St. Bonaventure, NY 14778

Additional mandatory paperwork:
• Medical Form
• Liability Waiver
Please visit: www.sbu.edu/CookChem
to download & print copies of these documents.
ST. BONAVENTURE UNIVERSITY
WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

1. In consideration for the opportunity to participate in (Insert name of camp) and other valuable consideration, by and through my execution of this document (hereinafter "WAIVER") I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE St. Bonaventure University, its officers, servants, agents, and/or employees (hereinafter "RELEASEES"). This WAIVER shall be construed as broadly as permissible under the laws of the State of New York, and is explicitly intended to preclude me from maintaining a civil action against RELEASEES in connection with any claims, demands, actions and causes of action whatsoever arising out of, or related to, any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the RELEASEES or otherwise while participating in such activity, or while in, on, or upon any premises where any portion of said activity is being conducted, as well as while in transit to and from said premises, or at any time at any location between my departure in connection with the above referenced activity and the time I complete my return from the activity.

2. I am aware of no physical or mental infirmity that could reasonably be construed to effect my ability to safely and fully participate in this activity, and I have not taken any action or made any representation to the RELEASEES regarding said ability which is untrue or upon which RELEASEES would be unjustified in relying with regard to my health, wellness and general ability to participate.

3. I am fully aware of risks and hazards connected with the activity, including but not limited to, the risks as noted herein involving travel, and I hereby elect to voluntarily participate in said activity, and to enter any involved travel arrangements and premises, and engage in the aforementioned activity knowing that the activity or necessary components thereto may be hazardous to me and my property. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury, including death, that may be sustained by me, or any loss or damage to property owned by me, as a result of being engaged in such an activity, whether caused by the negligence of RELEASEES or otherwise.

4. I further hereby agree to indemnify and hold harmless the RELEASEES from any loss, liability, damage or costs, including court costs and attorney’s fees, that may accrue due to my participation in said activity, whether caused by negligence of RELEASEES or otherwise.

5. It is my express intent that this Release and Hold Harmless Agreement shall bind the members of my family, spouse, or power of attorney if I am alive, and my heirs, assigns and personal representative if I am not alive. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of New York.

6. I understand and agree that the University shall not be responsible for any medical costs associated with any injury I may sustain.

7. I also understand that I should, and am urged by the University to, obtain adequate health and accident insurance to cover any personal injury to myself which may be sustained during the activity or the travel/transportation to, from and during said activity.

8. If any portion of this document is held to be void or unenforceable, then the minimum amount of the clause that must necessarily be severed from the remainder of the document to enable the clause, or the document as a whole, to become or remain valid and enforceable shall be severed. Upon the completion of said minimum severance, if at all possible, the remainder of the clause and document, shall be and remain in full force and effect to the greatest extent permissible under the laws of the State of New York.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by same.

IN WITNESS WHEREOF, I have hereunto set my hand on this ________ day of ________________________, 20___.

_______________________________________   ______________________________________
Participant Signature      Witness Signature
(Print name)______________________________   (Print name)_______________________________

_______________________________________
Parent/Guardian Signature
(Print name)______________________________
**Health History 2017**

The following information must be filled out by the parent/guardian (when the camper is a minor), or adult camper or staff member. The intent is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any change to this form should be provided to camp health personnel upon camper’s arrival in camp. Provide complete information so that the camp can be aware of your needs.

This form is confidential, observed only by camp health staff, medication staff and NYS Department of Health

**General Questions:** Explain "yes "answers below or on a separate piece of paper attached to this form.

The participant has/had:

- □ a recent injury, illness or infectious disease
- □ a chronic or recurring illness/condition
- □ an orthodontic appliance
- □ glasses, contacts, or protective eyewear
- □ problems with diarrhea/constipation
- □ problems with sleepwalking
- □ dizziness or fainting during or after exercise
- □ If female: abnormal menstrual cycle
- □ emotional difficulties for which professional help was sought

Use this space to provide any additional information about the camper’s behavior and physical, emotional or mental health about which the camp should be aware.

Allergies (list all known) Describe reaction and management of the reaction:

Medication allergies (list all) ____________________________________________

Food Allergies (list all) ____________________________________________

Other allergies (list all) ____________________________________________

**Medications to be taken at camp**

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

- □ This person takes no medication on a routine basis.
- □ This person takes medication as follows: (attach additional pages for more medications)

| PHYSICIAN’S STANDING ORDERS FOR THIS CAMPER |
| Health Care Provider MUST Fill Out and Sign |
|__________________________________________|

**DATE ___________________________**

**PATIENT/CAMPER:** ____________________________________________

**DIAGNOSIS:** ____________________________________________

<table>
<thead>
<tr>
<th>Drug</th>
<th>Acetaminophen</th>
<th>Ibuprofen</th>
<th>Pepto-Bismol</th>
<th>Benadryl</th>
<th>Maalox</th>
<th>Imodium</th>
<th>Cough Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission to Administer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosage</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER:** ____________________________________________

Prescription Medication: (please list) ____________________________________________

**Health Care Provider Signature & Date** ____________________________

**Parent/Guardian Signature & Date** ____________________________

Omission of signatures may delay necessary medical attention

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer:

__________________________________________

OVER
CAMPER MEDICAL FORM 2017

Parent or guardian please print or type all information clearly. Please fill out both sides of form. This information is important in the event of an accident at camp. Your child may not receive necessary and timely treatment without it.

Permission to Provide Necessary Treatment or Emergency Care (Please Read Carefully):
Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the doctor selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Parent/Guardian Signature: (Your child will not be admitted to camp without this signature).

Emergency Contact (If parents CANNOT be reached)
Restrictions at camp (please list):

Insurance Information
(Your child will not be admitted to camp without this information.)
Is the camper covered by family medical/hospital insurance? □ Yes □ No
If so, indicate carrier or plan name:
Group No.
Name of insured
Policy holder
Insurance ID No.
Relationship to camper
Medicaid Number

PHYSICIAN’S HEALTH ASSESSMENT FOR CAMPER

Health Care Provider MUST Fill Out and Sign

Immunizations You must supply all immunization information, including dates, for camper to be admitted to camp.

<table>
<thead>
<tr>
<th>Vaccine For:</th>
<th>Mo./Yr.</th>
<th>Mo./Yr.</th>
<th>Mo./Yr.</th>
<th>Mo./Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP (tetanus/diphtheria)</td>
<td></td>
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</tr>
<tr>
<td>Tetanus</td>
<td></td>
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<tr>
<td>Polio</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or Measles</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Or Mumps</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Or Rubella</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Haemophilus</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Influenza B</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
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</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td></td>
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</tr>
<tr>
<td>BCG</td>
<td></td>
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</tr>
</tbody>
</table>

Medical Care Providers:

Name of family physician:
Phone
Address

Name of family dentist/orthodontist:
Phone
Address

Check which of the following diseases the camper has already had:

☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis
☐ Small Pox

Does the camper have or has had in the past, any of the following:

Tuberculosis ☐ ☐
Hepatitis B ☐ ☐
Hepatitis C ☐ ☐
Bleeding Disorders ☐ ☐
Rheumatic Fever ☐ ☐
HIV Positive ☐ ☐
Heart Disease ☐ ☐
Other ☐ ☐

Date of camper’s last physical exam:

The camper must have had a physical exam no more than 2 years before the camp session for which they are registering.