



United Indian Health Services, Inc.

**May-Gay-Tolh-Kwe I  
"A Healing Place"  
Youth Summer Camp 2019**

**CAMPER REGISTRATION PACKET**

United Indian Health Services, Inc. (UIHS) is proud to announce that the Annual "May-Gay-Tolh-Kwe" Youth Summer Camp is scheduled to be held **Tuesday, July 9th - Friday, July 12th, 2019 at Patrick's Point State Park in Trinidad, California.**

"May-Gay-Tolh-Kwe" Youth Summer Camp 2019 will provide a safe and positive camping experience for American Indian youth. During camp, youth will be introduced to local cultural traditions and have the opportunity to participate in many activities that promote and encourage healthy lifestyle choices. All activities will be based on values inherent in our American Indian community, and will include topics such as diabetes prevention, building self-esteem, recycling, nutrition, and other wellness related presentations.

Campers will meet other American Indian youth from our community and together they will experience four days of fun, healthy and educational activities. Cultural activities such as necklace making, storytelling, traditional games and more will be introduced during summer camp. Youth will also participate in daily hikes, nature walks, and various sports activities.

All American Indian youth ages 9-11 that are registered at UIHS are eligible to participate. The summer camp will be limited to the first 80 eligible youth who submit the camper registration packet. Registration is based on a first come first serve basis with a priority for those clients who live within the UIHS service area. All forms must be completed and delivered to any UIHS clinic site.

**IMPORTANT REMINDERS:**

- \* **Parents must remain with campers during check-in.**
- \* **Campers can check-in between 9am-10am on Tuesday, July 9th.**
- \* **Campers must be picked up by 11 AM on Friday, July 12th.**

If you have any questions or need more information,  
please contact **UIHS Community Health & Wellness Department**  
at 707-825-5070 or 1-800-675-3693.

**Submit Camper Registration Packet at any  
UIHS Clinic Site**



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**What to bring:**

4 days of clothing. We are hoping for sun, but please make sure your camper is prepared for cloudy/cold weather conditions. Clothes that can be layered are the best. Bring extra sweatshirts and shoes. Write your name on all clothing and camping gear.

Long Pants	Toothbrush	Deodorant	Flashlight
T-shirts	Toothpaste	Hairbrush/Comb	Sleeping bag
Sweatshirts	Towels	Extra shoes	Extra blankets
Shorts	Washcloths	Extra jacket/sweatshirt	Pillow
Socks/Underwear	Soap	Bag for dirty clothes	Tent

\*\*\* A limited number of tents will be available for those who need them.

**Please DO NOT Bring:**

IPODS, MP3 players, CD players, Gameboys, cell phones or any other electronics, money or candy. UIHS will not be responsible for any items that are lost, stolen, or damaged at summer camp.

**Registration Packet Checklist:**

- Camper Information Form
- Parent/Guardian Consent Form
- Medical Authorization Form

**Emergency Contact Information:**

United Indian Health Services	707-825-5070
Red Alder Emergency Cell Phone	707-672-6072
Patrick's Point State Park (main office)	707-677-3570
Valerie Reed Camp Co-Director	707-672-6072
Andre Cramblit Camp Co-Director	707-845-4973



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**CAMPER INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: **Male Female**

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Message: \_\_\_\_\_

Registered UIHS Client: **Yes No** Birth Date: \_\_\_\_\_ Sweatshirt Size: \_\_\_\_\_  
Adult / Child (circle)

**Camper:** Please tell us why you are interested in attending May-Gay-Tolh-Kwe Summer Camp:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your experience with local American Indian culture and traditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any sports, hobbies and other activities that you are involved with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Camper Agreement:**

*As a camper, I agree to: attend and be on time to all functions and activities; cooperate with all staff, counselors and guest presenters; stay away from drugs, alcohol and tobacco; behave in a manner that honors my ancestors and traditions as an American Indian person.*

**Camper's Signature:** \_\_\_\_\_



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**PARENT/GUARDIAN CONSENT FORM**

I hereby give my minor child \_\_\_\_\_ permission to attend "May-Gay-Tolh-Kwe" Youth Summer Camp 2019 at Patrick's Point State Park from July 9-12, 2019.

**\*\*\* Note: Parent/Guardians are required to remain with their child throughout the check-in process.  
\*\*\* All items brought to camp are subject to search.**

**Head Lice:**

I understand that I must remain at camp with my child until he/she has been examined and cleared to be head lice/nit free. Children found to have head lice during check-in will not be allowed to participate in camp this year. This is for the protection of all camp participants. \_\_\_\_\_(initial)

**Presentations:**

I understand that my child will participate in presentations that will include information about making healthy lifestyle choices, diabetes prevention, nutrition, drug, alcohol and tobacco prevention, environmental education and other health related issues. \_\_\_\_\_(initial)

**Photographs/Video:**

I understand that my child may be photographed or participate in video documentation during camp activities. Further, I understand that these photos and videos may be used in the development of health promotion related educational materials. \_\_\_\_\_(initial)

**Early Dismissal:**

I understand that I will be contacted to pick up my child for any illness, behavior problems, fighting and abuse of any substance such as drugs, alcohol or tobacco. **UIHS will NOT** be able to provide transportation. \_\_\_\_\_(initial)

**Medication:**

If you child will require medication during summer camp, please provide the following information:

<i>Type of Medication</i>	<i>Dose Amount/Frequency</i>	<i>Special Instructions</i>
_____	_____	_____
_____	_____	_____

**\*\*\*NOTE: All medications must be provided to camp staff during the check-in process. Medications will be safely and properly stored and will be dispensed by camp staff to the minor child as required.**

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_



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**MEDICAL AUTHORIZATION FOR TREATMENT OF A MINOR**

I hereby authorize United Indian Health Services, Inc., as an agent for the undersigned to consent to any x-ray examination, anesthetics, medical, surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medical Practices Act or the medical staff of any hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent or agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. I hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to the above named agent upon completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety code of California.

These authorizations shall remain effective through July 20, 2019 unless sooner revoked in writing and delivered to said agent.

Minor Child's Name: \_\_\_\_\_

Parent/Guardian (print) \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_



**Medical History**

Minor Child's Doctor: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Food/Medicine Allergies: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_

**Insurance Information**

Insured's Name: \_\_\_\_\_

Name of Policy: \_\_\_\_\_

Policy Number: \_\_\_\_\_