



Northeast Missouri Area Health Education Center
312 S. Elson Street ♦ Kirksville, MO 63501
660.665.6404 ♦ fax 660.665.6439

June 2021

Dear Student & Parents:

Thank you for your interest in the **2021 M*A*S*H Camp**, coordinated by NEMO AHEC and our sponsors. This packet contains the preliminary enrollment information to register children for the camp. You are welcomed to make additional copies of these forms as needed.

Space is limited to students entering 9th, 10th, 11th, or 12th grade in the fall. You must complete and return mail the following documents to register for this camp.

- Demographic Data Form
- Registration & Parent Consent Form (2 pages)
- \$45 registration fee or written request for scholarship

NOTE: Make checks payable to NEMO AHEC.

A limited number of scholarships are available to families for whom the registration fee is a considerable hardship. To request a scholarship, please include a written request from parent explaining the hardship situation and requesting assistance from the planning committee. You will be notified at a later date if the scholarship is granted.

Do not delay!!! Registrations **CANNOT** be taken by phone or fax. Please mail the completed packet and payment to **NEMO AHEC, 312 S Elson St., Kirksville, MO 63501** or email to **lwallace@nemoahec.org**.

All forms must completed and turned in to NEMO AHEC by July 9th!

The Kirksville M*A*S*H Camp will take place July 20th, 21st, and 22nd from 8am-4pm at Moberly Area Community College- Kirksville.

The Hannibal M*A*S*H Camp will take place July 27th, 28th, and 29th from 8am-4pm at Moberly Area Community College- Hannibal.

Activities will take place indoors and outdoors under the supervision of camp personnel.

Sincerely,

Robin Worthington
Executive Director

Laura Wallace
Health Education Specialist

Enclosures

Date:	NEMO AHEC Center	Participant Code
-------	------------------	------------------

MAHEC Participant Registration Form

MAHEC is required to report general demographic information about participants. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.



Last Name	First Name	MI	Birthdate (mm/dd/yy)	Gender
-----------	------------	----	----------------------	--------

Address

City	County	State	Zip Code (9 digits if possible)
------	--------	-------	---------------------------------

Primary Phone #	Permanent Email Address
-----------------	-------------------------

Ethnicity (Select one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race (Select all that apply) <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai) <input type="checkbox"/> Asian (Other) <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White	Disadvantaged Status (Select all that apply) <input type="checkbox"/> I will be/am the first in my family to go to college <input type="checkbox"/> I grew up with English as my second language <input type="checkbox"/> I have been diagnosed with a physical or mental impairment that limits my participation <input type="checkbox"/> I qualify for federal tuition assistance <input type="checkbox"/> I qualify for the free and reduced school lunch program
---	---	--

Education Level (Select one) <input type="checkbox"/> Grades K-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-12 <input type="checkbox"/> Post High Sch/Pre-College <input type="checkbox"/> 2-Year College/Comm Coll <input type="checkbox"/> 4-Year College	<input type="checkbox"/> 12-Month Post-Baccalaureate <input type="checkbox"/> Pre-Matric/Pre-Grad School <input type="checkbox"/> Graduate School <input type="checkbox"/> Medical School <input type="checkbox"/> Dental School	Residential Background (Select one) <input type="checkbox"/> Frontier (Wide Open, Few People) <input type="checkbox"/> Rural (Country, Small Town) <input type="checkbox"/> Suburban (Small City) <input type="checkbox"/> Urban/Inner City (Big City)
---	--	---

Current School Name	City	County	State	Zip Code (9 digits if possible)
---------------------	------	--------	-------	---------------------------------

Current Grade/College Year	Counselor/Teacher/Advisor Name
----------------------------	--------------------------------

K-12 PARENT/GUARDIAN INFORMATION

Last Name	First Name	Primary Phone #	Permanent Email Address
-----------	------------	-----------------	-------------------------

Relationship	Address (If different from above)
--------------	-----------------------------------

City	County	State	Zip Code (9 digits if possible)
------	--------	-------	---------------------------------

INTERESTS

I intend to enter a health career: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what three health careers are you interested in?
---	--

I intend to enter a health career in primary care, such as family medicine doctor, nurse practitioner, physician assistant, general dentist, pediatric dentist, or community health worker: <input type="checkbox"/> Yes <input type="checkbox"/> No
--

I intend to work with people who are medically underserved or where there is not enough health care: <input type="checkbox"/> Yes <input type="checkbox"/> No

I intend to work in rural areas (not big cities): <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Connecting Students to Careers, Professionals to Communities, and Communities to Better Health

Northeast Missouri Area Health Education Center
Registration & Parent Consent Form
M*A*S*H Camps

2021

Student's Full Name _____

Nickname/Preferred Name _____

School Attending in Fall _____ Grade in Fall: _____

Emergency Contact #1 _____ Phone _____

Emergency Contact #2 _____ Phone _____

Family Doctor _____ Phone: _____

Family Dentist _____ Phone: _____

Please circle a t-shirt size for the child

Adult Sizes: Small Medium Large XL XXL

Are there any known food or other allergies; emotional or medical problems that we should be aware of? If so, please describe the condition and treatment required?

Are there any activity restrictions for the child? _____

If needed, do we have permission to give your child Tylenol or other over the counter medications?
YES _____ NO _____

Is the child currently on prescription medication? YES _____ NO _____

Name and purpose of medication (s) _____

Will dosage be required during the hours of 8am-4pm? YES _____ NO _____

If so, you must provide detailed dosing instructions 1 week before the camp.

In case of extreme emergency where immediate family cannot be reached, does AHEC have your permission to transport your child by emergency vehicle to the hospital? YES _____ NO _____

Hospital Preference _____ If the answer is no, what procedure do you request be followed? _____

I understand that should an emergency vehicle be requested to transport my child or emergency medical services provided, it is my responsibility to pay for the transportation the treatment of my child.

PARENTAL CONSENT:

I, _____ (Parent/Guardian) of _____ (student) hereby consent that my child may participate in the M*A*S*H* Camp which may include bus/van travel and walking trips within the community. I do hereby release the Northeast Missouri Area Health Education Center (NEMO AHEC); all M*A*S*H* Camp host facilities; all M*A*S*H* Camp staff and facilitators- including those providing transportation; all sponsors of the camp; and those acting under NEMO AHEC's permission or authority from any responsibilities of injury or accident as a result of this camp . I understand that any payment for treatment of injury or accident as a result of this camp is my responsibility.

Parent/Guardian Signature _____ Date _____

CONFIDENTIALITY AGREEMENT:

I hereby consent that while participating in M*A*S*H Camp activities my child may have opportunity to observe patients in a health care setting and to observe medical and laboratory procedures. This activity is a privilege which may expose my child to people with whom they know. I understand that patient confidentiality is of highest concern, therefore my child and I agree not to gossip or discuss the personal life of any patient seen at 2021 M*A*S*H camp.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

MEDIA RELEASE:

I authorize the Northeast Missouri Area Health Education Center (NEMO AHEC) and those acting under its permission or authority, to use and publish any (for lawful purpose whatsoever) video pictures/photographs of me in which may be included in whole, or in part, or any words I have spoken about M*A*S*H* Camp and its workers. I waive my right that I may have to approve the finished product or copy or use to which it may be applied. I release and discharge NEMO AHEC, Moberly Area Community College, and those acting under its permission or authority, from any liability for the use of any picture of me, or of any words I have spoken about the NEMO AHEC M*A*S*H* program and its workers.

I have read the release before signing it, and am fully familiar with the contents thereof.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____