

# City of Berea

**Berea Police & Fire Dept.**

**First Responders Summer Camp**



**First Responders and the Community we Serve**



**APPLICATION PACKET**

**July 13-17, 2026**

*Questions may be emailed to Officer Brent Bradley, Berea Police Dept.*

*bbradley@bereaky.gov*

# City of Berea First Responders Camp 2026 CAMPER APPLICATION FORM

Date \_\_\_\_\_

APPLICATION MUST BE DELIVERED TO FAMILY RESOURCE

CAMPER NAME \_\_\_\_\_  
(First) (Middle) (Last)

PREFERRED NAME (Goes By) \_\_\_\_\_ Gender: Male or Female

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Soc. Sec #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

School Attending: \_\_\_\_\_ Shirt Size: \_\_\_\_\_

PARENT / GUARDIAN'S NAME: (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

### RELATIVE OR NEIGHBOR CONTACT (MY CHILD CAN BE RELEASED TO THIS PERSON IF I AM NOT AVAILABLE)

NAME: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.) \_\_\_\_\_

ADDRESS: (street) \_\_\_\_\_ (city) \_\_\_\_\_ (zip) \_\_\_\_\_

PHONE: Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell : ( ) \_\_\_\_\_

Has camper attended a summer camp before: Yes No Where: \_\_\_\_\_ When: \_\_\_\_\_

Can child swim: Yes No

ACTIVITIES THAT THE CAMPER CANNOT PHYSICALLY PARTICIPATE IN

Swimming Running Other: \_\_\_\_\_

I AGREE TO OBEY ALL RULES AND REGULATIONS ON THE CAMP AND WILL COOPERATE WITH THE DIRECTIVES OF THE CAMP DIRECTOR, COUNSELORS AND STAFF.

Camper Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I GIVE THE CITY OF BEREA. PERMISSION TO ACCEPT MY CHILD TO BE A CAMPER AT THE CITY OF BEREA FIRST RESPONDERS CAMP AND FURTHER RELEASE CITY OF BEREA AND THEIR EMPLOYEES AND VOLUNTEERS OF ANY AND ALL LIABILITY FOR NEGLIGENCE.**

Signature of parent / guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**City of Berea & First Responders**  
**AUTHORIZATION TO USE PHOTOGRAPHS**  
**AND**  
**AUDIO VISUAL RECORDINGS**

I \_\_\_\_\_ , Parent of \_\_\_\_\_,  
(Please print) (Please print)

who has been selected to attend a camping session at The City of Berea, do hereby grant permission to The City of Berea, its officers, agents, employees, and other officials or designees, the right to use photographs and audio or visual recordings of my child taken or produced while my child attending or in the application process for attendance at the City of Berea First Responders Camp.

I further authorize the use of the photographs and audio or visual recordings, or reproductions thereof, to be used in written, video, website, or other medium used to promote The City of Berea. and its programs. This authorization includes both use in domestic and foreign markets or exchanges.

In my own behalf, and in behalf of my child, I relinquish and give to City of Berea, all right, title, and interest that my child or I may have any photograph, audio, or visual recording, or reproduction thereof, and further grant City of Berea, the right to give, sell, transfer, and exhibit any photograph, audio or visual recording or reproduction thereof, to any responsible individual, business firm or publication, or to any of their assignees.

I clearly understand that neither I, nor my child, will receive any compensation for the above grant authorization.

**Signature of parent / guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# City of Berea First Responders Camp 2026

## Camper Medical History and Release

(To be completed by Parent/Guardian)

Camper Name \_\_\_\_\_  
(Last) (First) (Middle)

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Last Immunization \_\_\_\_\_

**Insurance Information:** Is the camper covered by Family Medical/Hospital Insurance?  YES  NO

If so indicate Carrier or Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

Or does Camper have a Medical Card YES NO If so Card# \_\_\_\_\_

**Currently Taking Medication?** YES NO If Yes List Medications and Complete Medication Schedule on back of this Form.

**Has Child had lice within the past year?** Yes No If Yes when: \_\_\_\_\_

**Check any conditions that apply: MAKE SURE YOUR CHILD HAS THEIR MEDICATION WITH THEM**

Recent injury or Illness	Sleep Walking	History of Bedwetting
Frequent Headaches	Ever Had a Head Injury	Been Knocked Unconscious
Wear Glasses/Contacts	Frequent Ear Infections	Ever had Seizures
Have High Blood Pressure	Diagnosed with a Heart Murmur	Skin Problems
Have Diabetes	Has Asthma	Had Mononucleosis in the Past 12 Months
Ever had Surgery	Menstrual Cycle	Depression
Ever been Hospitalized	Ever Had Eating Disorder	Ever had Emotional Difficulties
Nose Bleeds	Heart Condition	Ulcer
Sinus Trouble	Convulsions	Fainting Spells
Speech Impediment	Deaf or Hard of Hearing	ADD/ OCD
ADH/ADHD	ODD	Head lice
Anxiety	*Other Not Listed	

\*Explain Not Listed Conditions: \_\_\_\_\_

### **Please List All Known Allergies:**

**Medication Allergies** \_\_\_\_\_

**Food Allergies** \_\_\_\_\_

**Other Allergies** \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

### **Parent or Guardian Emergency Contact:**

**Phone Number:** \_\_\_\_\_ **Cell Phone Number:** \_\_\_\_\_

Emergency Contact other than Parent or Guardian:

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Parents/Guardian: When we assume the responsibility of your child, we put his/her safety and health above all other considerations. Doctors are not permitted, by law to perform surgery and administer many other treatments to a child without the parent's consent. If the need arises, every effort will be made to allow you to make such decisions, but if circumstances make it necessary, you would want us to be free to act on behalf of your child, according to the best advice available. To make this possible, we ask that you sign the following statement and return it with the application.

**I HEREBY AUTHORIZE THAT PERSONS AND AGENCIES ENTRUSTED WITH THE CARE OF MY CHILD WHILE WITH THE CITY OF BEREА & FIRST RESPONDERS TO FOLLOW THE ADVICE OF THE BEST AVAILABLE MEDICAL AUTHORTIES AND ADMISISTER ANY TREATMENT, INOCULATIONS, MEDICINES AND SURGICAL PROCEEDURES DEEMED NECESSARY TO MY CHILD'S SAFETY. I ALSO AUTHORIZE THE CITY OF BEREА STAFF & FIRST RESPONDERS TO ADMINISTER ANY MEDICATIONS, AS DEEMED NECESSARY.**

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# CITY OF BEREA 2026 FIRST RESPONDERS CAMP

Camper's Name: \_\_\_\_\_

**INSTRUCTIONS:** The following **must be completed for each prescription** that is to be taken by your child during camp. Please list medication in the order in which they are to be taken. **This includes inhalers. ALL MEDICATION SHALL BE IN THEIR ORIGINAL PRESCRIPTION BOTTLES. ANY MEDICATION NOT IN THEIR ORIGINAL BOTTLE SHALL NOT BE ADMINISTERED.**

List of Medications 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  
 4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

## Breakfast

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

## Lunch

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

## Dinner

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

## Bedtime

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

## Other Note

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

