

REGISTRATION FORM

(Please use black or blue ink—
no gel pens or pencils, please.)

FOR OFFICE USE ONLY:	
Date Rec'd	_____
Event Name	_____
District	_____
Amt Rec'd	_____
Check #	_____
Cancell. Date	_____
Amt. Refund	_____

Event Title _____ **Date** _____

Cancellation Policy: over 30 days prior to event = full fee less \$25 handling fee; 15-30 days prior = 50% refund; 7-14 days prior = 25% refund; 6 days prior or no-show at event = no refund.

CAMPER NAME:

(Print) Last First Middle Initial

ADDRESS: _____

Street/Box Number

City State Zip

TELEPHONE: (_____) _____ **SEX:** M F **BIRTHDATE:** _____ **AGE:** _____

E-Mail _____ **Parents' Cell-Phone** _____

HOME CHURCH: _____ **CITY:** _____

Indicate Grade completed in School (as of June) _____

Indicate T-shirt Size: Youth: S M L Adult: S M L XL XXL

Will you allow your camper or yourself to be photographed and/or videotaped at camp? YES _____ NO _____

Check if this is your first, ever, summer camp experience. _____

Will you allow the Kansas Region to share the information on this form to the colleges/universities in Covenant with the Christian Church (DOC) ONLY for the purpose of providing information and resources about enrolling in a college related to the Disciples of Christ denomination? YES _____ NO _____

THE CAMP MINISTRY TEAM STRONGLY DISCOURAGES CAMPERS ARRIVING LATE OR LEAVING EARLY. ANY EXCEPTIONS MUST HAVE WRITTEN APPROVAL FROM THE CAMP DIRECTOR TWO WEEKS PRIOR TO CAMP OPENING.

PASTOR/ CHURCH LEADER, PLEASE COMMENT ON CHILD/YOUTH AND OTHER PERTINENT INFORMATION:

Signature of Pastor/Authorized Church Leader

WHAT IMPORTANT INFORMATION CAN YOU GIVE US ABOUT YOUR CHILD/YOUTH THAT WILL HELP US IN THE CAMPING PROGRAM? PLEASE INCLUDE ANY ACCOMMODATIONS NEEDED:

Signature of Parent/Guardian, if camper is minor

CAMP HEALTH FORM

(To be completed by parent/guardian if participant is a minor)

Name: _____ Weight: _____ Height: _____ Sex: F ___ M ___

PART I - Is the camper in general good health and able to participate in all normal camp activities:

___ YES ___ NO If not, please explain _____

Date of last complete physical examination: _____

Immunization: Date of last Tetanus shot _____

Health Concerns: Food Allergies _____

Allergic to: Penicillin _____ Sulfa _____ Insect Stings _____ Poison Ivy _____ Latex _____

Subject to Bedwetting _____ Asthma _____ Convulsions _____ Skin Rash _____ Fainting _____

Recent surgery: _____

Recent exposure to communicable disease: _____

Heart Disease: _____ Athlete's Foot: _____

Vision (check one): _____ eye-glasses _____ contact lenses

Information Camp Director should have: Additional volunteer staff may be needed to provide adequate supervision for any special needs. Camper may need to be sent home if sufficient information is not provided in this space. _____

Physical limitations _____

Mental limitations: _____

Emotional stress: _____

Behavioral disorders: _____

Medications: If parent/guardian sends any medications, it is required to be in the original container, with name and instructions printed on container.

If applicant is on any regular medication, state drug and dosage: _____

Applicant may have: ___ Acetaminophen ___ Ibuprofen ___ Aspirin ___ Antihistamine

Swimming ability: ___ Non-swimmer ___ Beginner ___ Intermediate ___ Advanced

Part II - Person to notify in case of emergency:

Name: _____ Relation to Applicant _____

Phone (Home) _____ (Business) _____ (Other) _____

Physician - Name _____ Phone _____

HEALTH CARE POLICIES

The medical payments provided to participants is written on an excess basis. This means that if the inferred party has other valid coverage that coverage would be primary and the Christian Church in Kansas would pay in excess to that other insurance. If there is no other coverage, then the Christian Church in Kansas coverage would be considered primary. Accidents that occur at any event or activity (on or off premises and including the use of boats) are covered.

Part III - Health and Accident Insurance: Please send a copy of the Insurance Card and provide the following information:

Name of Company

Policy Number

Part IV - In case of accident or illness:

I hereby give permission to the physician selected by the event director to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for (name of applicant).

Signature: _____ Date: _____