linkcamps

REGISTRATION FORM

Total cost for camp is $200.
Please turn in all forms along with payment by Sunday, July 17th.

NAME _____ Male Female
EMAIL _____

ADDRESS _____
CITY _____
STATE _____ ZIP_____

PHONE (HOME) _____
PHONE (OTHER)_____
PARENT(S) NAME(S) _____

PLEASE CIRCLE YOUR SHIRT SIZE (ALL SIZES IN ADULT)

S M L XL 2XL 3XL

PLEASE CIRCLE THE GRADE YOU ARE GOING INTO

6^{TH} 7^{TH} 8^{TH} 9^{TH} 10^{TH} 11^{TH} 12^{TH}

ANYTHING ELSE WE NEED TO KNOW

_____

PERMISSION FORM

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Information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care

PERSONAL INFORMATION

Name_____ Birthdate_____ Sex_____ Age_____

Parent or Guardian_____

Home Address_____ Phone_____

(1) Emergency Contact_____ Relationship_____

Home Address_____ Phone_____

(2) Emergency Contact_____ Relationship_____

Home Address_____ Phone_____

Name of Physician_____ Phone_____

Name of Dentist/Orthodontist_____ Phone_____

Medical/Hospital Insurance Carrier_____ Policy/Group #_____

MEDICAL INFORMATION

Health History:

Ear Infection_____

Convulsions_____

Diabetes_____

Bleeding/Clotting Disorders_____

Heart Defect_____

Hypertension_____

Bedwetting_____

Depression_____

Other_____

Childhood Diseases:

Chicken Pox_____

Measles_____

German Measles_____

Mumps_____

Mononucleosis_____

Other_____

_____

Physical History: (Give Dates)

Operations or Serious Injuries_____

_____

_____

Chronic or Reoccurring Illness/medical conditions

_____

_____

Dietary Restrictions

_____

_____

Allergies:
(Check all that apply)

Hay Fever_____

Ivy Poisoning_____

Insect Stings_____

Penicillin_____

Other Drugs_____

_____

Asthma_____

Anaphylactic Kit Y___ N___

Other _____

_____

Suggestions on health related information for camp personnel

_____

AUTHORIZATION: **The following section MUST be signed for the participant to attend Summer Camp**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization of Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of Parent/Guardian_____ Date_____

Friendship Baptist Church
Release of Liability & Consent for Medical Treatment

Name_____Birthdate_____Sex_____Age_____

Street Address_____City_____ State_____ Zip_____

EMERGENCY INFORMATION

Father's Name_____Home Ph _____ Cell ph _____

Mother's Name_____Home Ph _____ Cell ph _____

In an emergency when parent/guardian cannot be reached or is not applicable, please contact the following:

Emergency Contact_____ Relationship_____

Home Phone_____ Cell Phone_____

Name of Physician_____ Phone_____

Known allergies_____

Medicine Allergies_____

Other medical information (i.e.) current medications, diet restrictions, etc…_____

_____

Name of Insurance Policy Holder_____Phone #_____

Insurance Company Name_____ Policy #_____

Address_____ City_____ State_____ Ph_____

I, _____, hereby willingly consent to have my child _____ attend activities operated by Friendship Baptist Church. In the event that my child is injured while attending activities and require the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a physician. In the event treatment is called for, which a physician and/or hospital personnel refuses to administer with out my consent, I hereby authorize the lead adult of the group, or a member of the Friendship Baptist Church leadership to give such consent for me.

In the event it becomes necessary for that person to give consent for me, I agree to hold such person free and harmless of any claims, demands, or suits or damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a physician. I also acknowledge I that will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance carrier.

In signing this form, I also agree not to hold Friendship Baptist Church, its officers, employees, or other agents liable for any injury, loss, damage, or accident that my child might encounter while on their activity.

Further, I affirm that the health insurance information provided is accurate at this date and will, to the best of my knowledge, still be in force at the time of the activity.

****This release form is in effect June 5th 2016, thru June 4th 2017.**

Parents/Guardians Signature_____Date_____

Participant's Signature (If 18 or older)_____Date_____