



REGISTRATION FORM

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

NCME _____ 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

6TH 7TH 8TH 9TH 10TH 11TH 12TH

ANYTHING ELSE WE NEED TO KNOW



PERMISSION FORM

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 _____