

# REGISTRATION

**Only one camper and one program per registration form.**

**PLEASE PRINT**

Camper's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
(PO Box, Street or Rural Route)

(City or Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Emergency Phone No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ School Grade Next Year \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Father's Name \_\_\_\_\_  
(First) \_\_\_\_\_ (Last) \_\_\_\_\_

Mother's Name \_\_\_\_\_  
(First) \_\_\_\_\_ (Last) \_\_\_\_\_

Church Attending \_\_\_\_\_ Baptized?  Yes  No

## PROGRAM I PLAN TO ATTEND

Program \_\_\_\_\_ Date \_\_\_\_\_

**Pre-Registration Fee:**

Full Weeks \$25  
Day Camp \$10  
First Chance \$10  
High Adventure \$50

**FOR OFFICE USE ONLY**

Pre-Registration Paid  
by Camper \$ \_\_\_\_\_  
or by Church \$ \_\_\_\_\_  
Balance Registration Paid  
by Camper \$ \_\_\_\_\_  
or by Church \$ \_\_\_\_\_  
Balance Due Bill Church \$ \_\_\_\_\_

The following information **MUST BE FILLED IN** and **SIGNED BY A PARENT OR GUARDIAN**. Failure to do so may result in the camper being refused permission to stay.

I certify that \_\_\_\_\_

is in good physical condition and is able to participate in all camp activities

(except): \_\_\_\_\_

Camper's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medications presently taking: \_\_\_\_\_

**All Medication is to be Left With and Disposed by Camp Nurse**

PLEASE CHECK IF CAMPER HAS ANY OF THE FOLLOWING:

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Trouble   | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Ear Infection   | <input type="checkbox"/> Sleep Walking        |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Fainting             |

Do you give your child Tylenol?  Yes  No

Has Camper had any serious injuries or surgery?  Yes  No

Date of last tetanus shot \_\_\_\_\_

List allergies \_\_\_\_\_

Comments \_\_\_\_\_

**SEE REVERSE FOR INSURANCE INFORMATION**

**MAIL TO:**

Camp Christian  
P.O. Box 230  
Mill Run, PA 15464

Phone: 724-455-2700  
E-mail: [comecus@Lhtot.com](mailto:comecus@Lhtot.com)  
[www.camp-christian.org](http://www.camp-christian.org)

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Family Insurance Co. \_\_\_\_\_

Policy Number \_\_\_\_\_

Family Physician \_\_\_\_\_

His/Her Address \_\_\_\_\_

His/Her Phone \_\_\_\_\_

To the best of my knowledge, my child is physically and emotionally able to take part in the camp program. In the event of a Medical Emergency, I give my permission to those in charge at Camp Christian to seek necessary medical attention from qualified personnel (Camp Nurse, EMT or other Medical Professionals) to do what is necessary for the health and well being of my child.

My signature also allows for photos taken of my child during his/her camp program to be used in future camp promotional materials.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_