

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

www.camp-christian.org

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 _____