

2010 Kids Camp Registration Form

Please Print

Name _____

Date of Birth ____/____/____

Circle: Male / Female

Age _____

Grade completed _____

Address _____

Phone (including area code) _____

E-mail _____

Name of parents or guardian with whom child lives: _____

Address (if different from above): _____

Day Phone #: _____ Cell Phone #: _____

Evening Phone #: _____

Emergency Contact Person _____

Relation to camper _____ Phone # _____

CHECK THE CAMP YOU WILL BE ATTENDING

- Kids Camp 1 – July 5-9 Speaker: Pastor Dave White & Pastor David Clymer
- Kids Camp 2 – July 12-16 Speaker: Pastor Russell Smith
- Kids Camp 3 – July 19-23 Speaker: Pastor Christopher Peterson

How many years have you attended camp? _____

Church Name _____

Church City _____

I have read all of the rules regarding camp, and I will obey and abide by all camp rules.

Camper's Signature (Required) _____

REGISTRATION COST: Early Registration Rate: \$145* Regular Rate: \$155
Camp Theme T-shirt: \$10

**(Must be postmarked 14 days prior to start of camp the student is attending in order to receive discount.)*

Amount Enclosed: _____ Check each appropriate box <i>T-shirts are optional</i> <i>Theme T-shirts will be available at camp for \$12.00 each. Order in advance for \$10.00 each.</i>	_____ Registration _____ T-shirt Youth _____ Size Adult _____ Size _____ \$45 registration deposit <i>(balance due on arrival)</i>
Make Check payable to:	Georgia District Assemblies of God
Mail Completed Application to:	P.O. Box 28470 Macon, GA 31221

EMERGENCY MEDICAL AUTHORIZATION/INFO FORM

This medical emergency form must be signed by a parent or legal guardian, and accompany the child or young person who wishes to participate in Kids Camp. The purpose of the form is to make it possible for parents and guardians to authorize the provision of emergency treatment for young people and children who become ill or injured while under camp authority. You can authorize such emergency medical treatment for your child by completing this form.

INFORMATION

CHILD NAME _____ BIRTH DATE ___/___/___

ADDRESS _____ CITY _____ ZIP _____

CHILD PHYSICIAN _____ PHONE _____

MEDICAL INSURANCE CARRIER _____

POLICY/GROUP # _____

SPONSOR/LEADER NAME _____

CHURCH _____ CITY _____

IMMUNIZATIONS (Provide a copy of most recent record if available):

Last Tetanus shot: _____

CHRONIC/RECURRING CONDITIONS:

<u>CONDITION:</u>	<u>TREATMENT GIVEN</u>
_____ Asthma	_____
_____ Bronchitis	_____
_____ Other respiratory problems	_____
_____ Seizures	_____
_____ Diabetes	_____
_____ Fainting	_____
_____ Frequent Headaches	_____
_____ Migraines	_____
_____ Heart Problems	_____
_____ Kidney problems	_____
_____ Urinary problems	_____
_____ Digestion (Constipation, Diarrhea)	_____
_____ Upset Stomach (acid reflux, heartburn, nausea)	_____
_____ Nosebleeds	_____
_____ Bleeding problems (Hemophilia)	_____
_____ Other (specify below)	_____
_____	_____

ALLERGIES (check all that apply, be specific)

TYPE:	REACTION NOTED
<input type="checkbox"/> Animals	_____
<input type="checkbox"/> Food	_____
<input type="checkbox"/> Insect Bites/stings	_____
<input type="checkbox"/> Plants	_____
<input type="checkbox"/> Pollen	_____
<input type="checkbox"/> Medications	_____
<input type="checkbox"/> Other	_____

Over the counter medications that may be given by camp nurse (check all that apply)

<input type="checkbox"/> Tylenol	<input type="checkbox"/> Advil
<input type="checkbox"/> Benadryl	<input type="checkbox"/> Lomodil
<input type="checkbox"/> Pepcid	<input type="checkbox"/> Claritin
<input type="checkbox"/> Tums	<input type="checkbox"/> Pepto-Bismol
<input type="checkbox"/> Immodium	<input type="checkbox"/> Cough Syrup
<input type="checkbox"/> Nasal decongestant	<input type="checkbox"/> Nasal Spray

CURRENT MEDICATIONS:

Is the medication in the child's possession? Yes No

Child wears: _____glasses _____Contacts _____Dental application _____Other(explain)

Are there any other pertinent facts to which a physician should be alerted?

PARENT/GUARDIAN STATEMENT: I authorize the adult in charge to consent to any medical treatment deemed necessary by the appropriate licensed physician or dentist or medical personnel of the hospital that serves the Georgia District Council when I cannot be contacted. I understand that every effort will be made to contact me before such action is taken. I assume financial responsibility for emergency care if such care is not covered by the churches insurance.

DATE: _____

(Signature of parent or guardian)

Home Phone# _____

Cell# _____

Alternate contact info if parent/guardian cannot be reached
