

Camp Union Registration Form

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|--|--|--|
| <input type="radio"/> First Chance (K-1 st) | <input type="radio"/> Elementary Week 2 (2 nd -4 th grade) | <input type="radio"/> Junior High Week (7 th -8 th grade) |
| <input type="radio"/> Elementary Week 1 (2 nd -4 th grade) | <input type="radio"/> Breakout Week (5 th -6 th grade) | <input type="radio"/> High School Week (9 th -12 th grade) |

Name: _____ M / F Email address: _____

Address: _____

City: _____ State & Zip: _____

Phone: _____ Grade going into: _____ Age as of 7/1: _____

Parent's Names: _____ Emergency Phone Number: _____

Church: _____ Pastor: _____

Church/Pastor Phone: _____ Camp T-Shirt Size: Child M L Adult S M L XL XXL

Are there any custodial issues that we need to be aware of concerning this child? Yes or No (If Yes, please explain):

I give permission for my child to travel off of camp property with authorized staff for camp activities.

Parent/Guardian Signature _____ Date _____

I authorize the taking of still photographs; color slides; audio-visual, and visual tape recordings of my child. I understand that these may be used within appropriate settings outside of Camp Union, provided that in such use, my child will not be identified by first and last name.

Parent/Guardian Signature _____ Date _____

My signature here acknowledges that I have read, understand, and consent to the above conditions as well as the medical terms on the reverse side of this registration form and that all information is as complete and as accurate as possible, to the best of my knowledge.

I understand that my child may be sent home due to inappropriate behavior or actions, as determined by the camp Board and Youth Directors.

Parent/Guardian Signature _____ Date _____



Please return this form along with your \$10.00 non-refundable deposit to:
 Camp Union Registrar
 PO Box 86
 West Mansfield, OH 43358

*Shaded area for Office Use only.

Fee			
Balance			



Medical Form

PLEASE ATTACH A COPY OF INSURANCE OR MEDICAL CARD TO THIS FORM (FRONT & BACK)

Camper: First Name Last Name Date of Birth: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Medical Insurance: _____ Subscriber's Name _____

Employer _____ Subscriber # _____ Group # _____

HEALTH HISTORY (approximate dates)

Ear Infections _____

Sinusitis _____

Bronchitis _____

Diabetes _____

Bleeding/Clotting _____

Hypertension _____

Heart Defect _____

Mononucleosis _____

Other: _____

Other: _____

DISEASES

Chicken Pox _____

Measles _____

German Measles _____

Mumps _____

Date of Last Tetanus: _____

Allergies

Yes	No	If "yes" what treatment has been given? Please attach a separate sheet, if necessary:
Hay Fever	_____	_____
Poison Ivy	_____	_____
Poison Oak	_____	_____
Insect Stings	_____	_____
Asthma	_____	_____
Penicillin	_____	_____
Other	_____	_____

Operations or serious injuries (please provide dates): _____

Chronic or recurring illness or medical condition: _____

Dietary Restrictions: _____

Other Diseases: _____

Activity Restrictions: _____ Swimming _____ Diving _____ Hiking _____ Other: _____

Date of last physical exam: _____ Anything special we should be aware of? _____

For Girls: has she menstruated? _____ If not, has she been told about it? _____ If yes, is her history normal? _____

List current Medications: _____

**All medications must be brought to camp in the original prescription container(s) with the pharmacy label attached.
All medication must be given to the camp nurse or administration at registration.**

Mother _____ Father _____

Home Phone _____ Home Phone _____

Work/Cell Phone _____ Work/Cell Phone _____

Address _____ Address: _____

If parents are not available in an emergency, the person to notify is:

Name _____ Relationship to Camper _____

Home address _____ Home Phone _____

City _____ State _____ Zip _____ Work/Cell Phone _____

I GIVE MY PERMISSION for my child to have emergency medical treatment. In the event that all reasonable attempts to contact me at the numbers provided on this form have been unsuccessful, or in the event that immediate action is considered necessary to preserve life, I hereby give my consent to administration of emergency treatment by a licensed physician or dentist and to the transfer of my child to any reasonably accessible hospital facility. This authorization DOES NOT include major surgery unless the medical opinion of two other licensed physicians or dentists are obtained prior to surgery.

Signature of Custodial Parent or Legal Guardian _____ Date _____

(Must be signed in front of a Notary)

State _____ County of _____ Before me, a Notary Public in and for said country and state this day of ____/____/____, personally appeared _____ (parent or guardian) and acknowledged execution of the foregoing, IN WITNESS WHERE I have hereunto set my hand and Notary Seal.

My Commission expires ____/____/____ _____

Notary Public

This needs to be completed by an adult!