



CABIN #: _____

Heartland Baptist Association
KID'S CAMP
(GRADES 3-6) July 23-26, 2021

CAMPER REGISTRATION FORM

(MUST BE COMPLETED BY PARENT OR GUARDIAN: NOT BY THE CAMPER)

Please use **dark ink** when completing this form and **print** clearly! Turn this form and registration fee in to your church. The church must have the forms and registration fees **IN** the Association Missions Center by the deadline date. Camp Fee \$115 Due Upon Registration - **Deadline is June 20, 2021**; \$25 late fee after deadline. Camp Fee includes a camp T-shirt and a snack shack ticket.

T-SHIRT SIZES: (Adult Sizes only; Circle One)

	Small	Medium	Large	X-Large	XX-Large	XXX-Large	
NAME _____							Grade Completed 3 4 5 6
M _____ F _____							
Age _____							
Birth Date ____/____/____							
ADDRESS _____							CITY _____ STATE _____ ZIP _____
PHONE () _____							CHRISTIAN? Yes No CHURCH MEMBER? Yes No
CHURCH NAME & LOCATION _____							
ADDRESS _____ CITY _____ STATE _____ ZIP _____							

IF YOU WANT TO BE IN A GROUP WITH SOMEONE, PUT THEIR NAME HERE _____
We **cannot** guarantee you will be grouped with this person. You cannot ask to be put with any other person after the forms deadline date of June 23rd.

CAMPER MEDICAL INFORMATION

CHECK AND COMMENT ON ALL THAT APPLY:

ALLERGIES:

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bee/insect sting	<input type="checkbox"/> Sulfa/other drugs	<input type="checkbox"/> Poison Ivy
<input type="checkbox"/> Sunburn easily	<input type="checkbox"/> Tetanus shot	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Aspirin/Tylenol
<input type="checkbox"/> Other (list) _____			

HAS HISTORY OF/UNDER MEDICAL CARE FOR:

<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Skin disorder	<input type="checkbox"/> Asthma
<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hernia	<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Athletes foot	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Other (Explain) _____			

SUBJECT TO:

<input type="checkbox"/> Homesickness	<input type="checkbox"/> Cramps	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Headaches	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Exhaustion	<input type="checkbox"/> Fainting	<input type="checkbox"/> Toothaches	<input type="checkbox"/> Swimmer's ear
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Cold/pneumonia	<input type="checkbox"/> Stomach/digestive disorders	
<input type="checkbox"/> Afraid of the dark	<input type="checkbox"/> Moody periods	<input type="checkbox"/> Other (Explain): _____	

FOR GIRLS ONLY

Has she been told about menstruation? _____ Has she started menstruation yet? _____ Will she have her period during camp? _____

LIST ANY ACTIVITY THE CAMPER SHOULD NOT PARTICIPATE IN: _____
(The remainder of this form is found on the back of this page. Please complete all required information.)

MEDICATIONS REQUIRED WHILE AWAY FROM HOME: PLEASE LIST AND DOSAGE!

Name of medication _____

For _____

Instructions _____

(All medications should be checked in with the camp nurse. Medication must be in original container)

Any medications that should NOT be given? _____

Date of last Tetanus shot ____/____/____ Other shots up-to-date? Yes No

FAMILY PHYSICIAN _____ PHONE () _____

NAME OF INSURANCE CARRIER _____ POLICY # _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

MEDICAL RELEASE: I (we) have provided complete and accurate information about this camper on both Registration Form and Medical Information Form and understand that, in the event medical treatment is required, every effort will be made to contact me(us) or the other person named below. However, if I(we) cannot be reached, I(we) give permission to the staff or sponsor to secure the medical services deemed necessary to provide for this camper's well being. I(we) also understand that the insurance provided by Grand Oaks Baptist Assembly, Inc. is a limited supplemental policy covering only injury or accidents occurring during the event at Grand Oaks, and will only be used to supplement the family insurance. I(we) also understand that any or all of this information may be used by the Camp Director, Camp Nurse, or Cabin Leader. I (we) also have **read** the attached General Information Sheet and **agree** to its contents.

BOTH PARENTS OR ALL LEGAL GUARDIANS MUST SIGN THIS FORM!

PARENTAL/GAURDIAN INFORMATION

NAME _____ RELATIONSHIP _____
Please print

IS THE FOLLOWING ADDRESS THE SAME AS THE ABOVE NAMED CAMPER? _____ YES _____ NO

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ CELL PHONE () _____

WORK PHONE () _____ E-MAIL ADDRESS _____

Signed _____ Sole Guardian/Parent: _____ YES _____ NO Date ____/____/____

NAME _____ RELATIONSHIP _____
Please print

IS THE FOLLOWING ADDRESS THE SAME AS THE ABOVE NAMED CAMPER? _____ YES _____ NO

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ CELL PHONE () _____

WORK PHONE () _____ E-MAIL ADDRESS _____

Signed _____ Date ____/____/____