

GROUP/ROOM \_\_\_\_\_



*Grand Oaks Baptist Assembly's*

# INTRODUCTION TO CAMPING (Grades 1-3)

June 22-23, 2018

## STAFF/PARENT/CABIN LEADER REGISTRATION FORM

**PLEASE USE BLUE OR BLACK INK PEN ONLY**

Turn this form and registration fee in to your church. The church or association must send proof of cleared background check on any adult coming to camp. Cabin Leader Fee \$25, Due Upon Registration – **Registration Deadline is June 18, 2018**

CAMP POSITION \_\_\_\_\_ T-shirt size: S M L XL XXL

Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_

Church Membership (Name & Location) \_\_\_\_\_ City \_\_\_\_\_

Have You Ever Served in Camp Before? \_\_\_\_\_ If So in What Position? \_\_\_\_\_

Have You Ever Been Formally Charged with Child Abuse, Sexual Abuse or Assault or Any Other Criminal Offense? Yes No

If yes, explain \_\_\_\_\_

Are There Any Activities in Which You Could Not Help or Participate? (Explain)

\_\_\_\_\_  
\_\_\_\_\_

### **IN CASE OF EMERGENCY, NOTIFY:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

WE DO APPRECIATE YOUR GIVING THIS WEEKEND TO HELP  
CHANGE THE LIVES OF SOME YOUNG PEOPLE.

**Medical Form on the backside of this page must be completed and signed.**

# STAFF/PARENT/CABIN LEADER MEDICAL INFORMATION

NAME \_\_\_\_\_

CHECK AND COMMENT ON ALL THAT APPLY:

**ALLERGIES:**

Penicillin       Bee/insect sting       Sulfa/other drugs       Poison Ivy  
 Sunburn easily       Tetanus shot       Hay fever       Aspirin/Tylenol  
 Other (list) \_\_\_\_\_

**HAS HISTORY OF/UNDER MEDICAL CARE FOR:**

Heart trouble       Tonsillitis       Asthma       Epilepsy/seizures  
 Appendicitis       Hernia       Bronchitis       Diabetes  
 Nervous disorder       Athletes foot       Stomach ulcer       Skin disorder  
 Other (Explain) \_\_\_\_\_

Recent injury or illness \_\_\_\_\_

**SUBJECT TO:**

Cramps       Convulsions       Sore throat       Headaches  
 Nosebleeds       Earaches       Fainting       Toothaches  
 Swimmer's ear       Cold/pneumonia       Stomach/digestive disorders  
 Other (Explain) \_\_\_\_\_

**MEDICATIONS REQUIRED WHILE AWAY FROM HOME:**

Name of Medication \_\_\_\_\_

For \_\_\_\_\_

Instructions \_\_\_\_\_

(All medications should be checked in with the camp nurse.)

Any medications that you CANNOT TAKE? \_\_\_\_\_  
(aspirin, cough drop, etc.)

FAMILY PHYSICIAN \_\_\_\_\_ Phone (      ) \_\_\_\_\_

NAME OF INSURANCE CARRIER \_\_\_\_\_

POLICY # \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_

**MEDICAL RELEASE:** I have provided complete and accurate information about myself and understand that, in the event medical treatment is required, and I cannot speak for myself, every effort will be made to contact the person listed in case of emergencies. However, if they cannot be reached & I cannot give my permission, permission is given to the staff to secure the medical services deemed necessary to provide for my well being. I 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 HAVE ALSO READ AND UNDERSTOOD THE INFORMATION SHEET PROVIDED WITH THIS FORM AND AGREE TO ITS CONTENTS.

Signed \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Last updated 2/22/2018-GRP)