**Cost: $50 ea. ~Please include your check or cash with the registration~**

**August 5-8 Calvary Kids Day Camp ages 9-16**

| **Wednesday** Aug. 5th 6pm PotLuck & Family Bible Study Kick Off

**Thursday** 3-7, **Friday** 3-Overnight, **Saturday** 10am Pick-up |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ time of camp \_\_\_\_\_ Gender( ) M ( ) F

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ T-Shirt Size: youth\_\_\_\_\_\_\_ adult\_\_\_\_\_\_\_

Custodial Parents/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact other Than Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Date of Birth \_\_/\_\_\_/\_\_\_

Medical Consent: I consent to and authorize emergency and non-emergency medical care to be provided to my child in the event of a health problem, emergency or injury occurring during my child’s attendance at camp. I give my consent and authorization to the camp director or his/her designee to use his/her judgment in seeking medical care for my child. I understand that an attempt will be made to contact me in the event that medical care is needed, and that I am responsible for all medical costs incurred in treating my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian Date

**PHOTOGRAPHY RELEASE**

I authorize Calvary Chapel Maryville to use photographs and statements of/by/about the camper during any part of Calvary Kids Camp on their website.

**\*This is required for camp registration acceptance. It is too difficult to keep track of those who opt out.**

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**WAIVER AND RELEASE**

I wish to enroll my child in the Calvary Kids Camp. I recognize that some of the activities involve physical risk, including the risk of serious injury. I hereby agree, on behalf of my child and myself, to assume all of the risks in connection with my child’s attendance. I affirm that I have read and understood this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian Date

**Important Health Information:**  (To be completed by parent or guardian).

|  |  |
| --- | --- |
| Allergies ( ) No Known Allergies( ) To Food (list and describe reaction):( ) To Medications (list and describe reaction):( ) To the Environment i.e. hay fever, insect stings (list and describe reaction):( ) Other Allergies (list and describe reaction): | Medical Conditions: List All |
| Factors Limiting Physical Participation/Mental Health Conditions: |
| Does your child wet the bed? ( )Yes ( ) NoDoes your child sleepwalk? ( )Yes ( )NoIs your child prone to homesickness? ( )Yes ( )No |
| Is there any other information you would like Calvary Kids Camp staff to know? |

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS: the following medications are available at Calvary Chapel Youth Retreat of occasional use as needed. Please check approved medications.

|  |  |  |
| --- | --- | --- |
| For Headache/Minor Pain( )Tylenol( )Advil | For Stomach/Bowel Upset( )Tums ( )Pepto Bismol( )Maalox ( ) Milk of Magnesia | Other Topical Products( )Insect Repellant ( )Sunscreen( ) Hydrocortisone Ointment( ) Benadryl Anti-Itch Gel |
| For Cold/Allergy Symptoms( )Benadryl( )Claritin( )Robitussin Cough Syrup( )Throat Lozenges | For Poison Ivy( )Calamine Lotion | Does your child swallow pills?( )Yes ( ) No |

I authorize the camp nurse or designee to assess the need for and appropriately administer the above checked medications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian Date

Current Medications: **“Medication”** is any substance a person takes to maintain and/or improve their health. This included vitamins. Provide enough of each medication to last the entire retreat.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Reason for Taking It | When is it given | Amt/Dose Given | How is it given |
|  |  | ( ) Breakfast( ) Lunch( )Dinner( ) Bedtime |  |  |
|  |  | ( ) Breakfast( ) Lunch( )Dinner( ) Bedtime |  |  |
|  |  | ( ) Breakfast( ) Lunch( )Dinner( ) Bedtime |  |  |
|  |  | ( ) Breakfast( ) Lunch( )Dinner( ) Bedtime |  |  |

**(Please attach a separate form with additional medications as needed)**

The above information and directions for administration of all medications is complete and correct. I authorize the retreat staff to use his/her discretion in giving the above medications as indicated.

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