GROUP/ROOM _____

*Grand Oaks Baptist Assembly's*

# INTRODUCTION TO CAMPING (Grades 1-3)

June 23-24, 2017

## STAFF/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 19, 2017**

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/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 4/26/2017-GRP)**