COMPLETION OF BOTH SIDES REQUIRED FOR ALL CAMPERS – 2010 REGISTRATION FORM

REGISTRATION DEADLINE is the WEDNESDAY BEFORE the first day of the camp you plan to attend.

1) Detach this page from brochure.
2) **COMPLETE ALL INFORMATION** on both the **registration form** AND the **health form**. NOTE: Form will be returned if not signed in both places by parent/guardian. Campers are accepted by GRADE COMPLETED as of the end of JUNE 2010. WE DO NOT GO BY AGE LEVELS – **NO EXCEPTIONS**.
3) Secure Pastor's signature, when possible.
4) Enclose full payment payable to Baptist Camp Lebanon. (Be sure to add $10.00 if after June 1st) **OR** enclose the MINIMUM $50.00 **non-refundable** deposit. Balance due no later than on registration day.
5) Mail to: Registrar, Baptist Camp Lebanon
79 Blossom Hill Road
Lebanon, NJ 08833

Event Camp No. L- _____From: _____ To: _____

Camper's Last Name | First | Birth Date | Age in June | Grade Completed in June 2010

_____

Street Address | City | State | Zip | Male ____

_____ Female ____

Email Address

_____

Parent/Guardian Name (please print) | Home Phone | Additional Emergency Phone

_____ (_____)_____ (_____)_____

Signature Parent/Guardian (**REQUIRED**) | Business Phone | Cell Phone

_____ (_____)_____ (_____)_____

Church Name | Denomination

_____

Address

_____

Pastor's Signature (**required if indicating church campership**)

X_____

Total Fee for Event	$_____
Amount Church Campership	$_____
Amount Church Enclosing	$_____
Amount Parent/Guardian Enclosing	$_____
Balance Due from Church	$_____
Balance Due from Parent/Guardian	$_____

NOTES FOR REGISTRAR/COUNSELOR

2010 HEALTH FORM – MUST BE COMPLETED IN FULL AND SIGNED BY PARENT/GUARDIAN

Camper's
Last Name _____ First Name _____ Event Camp L-_____

Is this child covered by medical insurance? Yes _____ No _____

Is this person in general good health and able to participate in normal activities? Yes _____ No _____
(If not, please submit a statement indicating limitations)
Problems with (check if YES).
____ Hayfever ____ Fainting ____ Penicillin
____ Bee Sting ____ Convulsions ____ Asthma
____ Poison Ivy ____ Sulfa ____ Other
____ Epilepsy (degree) _____ Allergies _____

If any of the above are YES, please submit a statement of how the child has been treated and with what medication. Proper medicine must be brought to the camp and given to the nurse.

All immunization will be the responsibility of the family in consultation with family physician or clinic. **Give most recent date of Tetanus Booster.** Then check the appropriate yes or no column to determine if camper has had necessary immunizations.

TETANUS BOOSTER (DATE REQUIRED)
most recent date received: _____

Received:	Yes	No	Received:	Yes	No
D.P.T. Series	___	___	D.P.T. Booster	___	___
Polio Series	___	___	Polio Booster	___	___
Mumps	___	___	Rubella Vac	___	___
Measles Vac	___	___			

Operation or serious injury and date(s) _____

_____
Please notify us if this child was exposed to any communicable disease during the three weeks prior to event. Please write a note below to indicate any physical, emotional or psychological problem that will help the Nurse and Counselor provide the best possible experience.

NOTES FOR NURSE

_____

_____

_____

Family Physician or Clinic _____

Address _____

Phone _____
In signing this application, I hereby certify that the above information is correct and give permission for the use of photographs including my son or daughter in publicity; for my son or daughter to be transported in camp-owned and camp approved vehicles to and from public transportation or for approved out-of-camp activities, and for the release of medical records in case of illness. I also authorize the administration of prescription medication. Non-prescription medication shall be administered in accordance with the camp's standing orders.

In case of medical emergency, I understand that every effort will be made to contact parents or guardian of camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named herein.

I understand that this child must be covered by medical insurance to be accepted into the camp program at Baptist Camp Lebanon

SIGNATURE OF PARENT/GUARDIAN (REQUIRED)

X _____

Telephones during camp: Day (_____)_____

Night (_____)_____ Cell (_____)_____

Name & address of your health insurance company _____

_____

_____

Policy/Group # _____

Name of Primary Insured _____

Date of Birth of Primary Insured _____

Social Security # of Primary Insured _____

Relationship of Camper to Primary Insured _____