

COMPLETION OF BOTH SECTIONS REQUIRED FOR ALL CAMPERS – 2008 REGISTRATION FORM

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

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| <p>1) Detach this page from brochure.</p> <p>2) COMPLETE ALL INFORMATION on both the registration form <u>AND</u> 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 08. WE DO NOT GO BY AGE LEVELS – NO EXCEPTIONS.</p> <p>3) Secure Pastor's signature, when possible.</p> | <p>4) Enclose full payment payable to Baptist Camp Lebanon. (Be sure to add \$10.00 if after June 1st) OR enclose the MINIMUM \$25.00 non-refundable deposit. Balance due <u>no later than on registration day.</u></p> <p>5) Mail to: Registrar, Baptist Camp Lebanon 79 Blossom Hill Road Lebanon, NJ 08833</p> |
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Event Camp No. L- _____ From: _____ To: _____

Camper's Last Name _____ First _____ Birth Date _____ Age in June _____ Grade Completed in June 2008 _____

Street Address _____ City _____ State _____ Zip _____ Male _____

Female _____

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) _____

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| <p><input checked="" type="checkbox"/> _____</p> | <p>Total Fee for Event \$ _____</p> <p>Amount Church Campership \$ _____</p> <p>Amount Church Enclosing \$ _____</p> <p>Amount Parent/Guardian Enclosing \$ _____</p> <p>Balance Due from Church \$ _____</p> <p>Balance Due from Parent/Guardian \$ _____</p> |
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2008 HEALTH FORM

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

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 attach a note to indicate any physical, emotional or psychological problem that will help the Nurse and Counselor provide the best possible experience.

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.

SIGNATURE OF PARENT/GUARDIAN (**REQUIRED**)

X _____

Telephones during camp: Day (_____) _____

Night (_____) _____ Cell (if applicable) (_____) _____

Name of your health insurance company _____

Policy/Group # _____