

PLEASE CHECK CAMP OR RETREAT ATTENDING

- | | |
|---|---|
| <input type="checkbox"/> Junior Retreat (currently in grades 3-5) | <input type="checkbox"/> Junior Camp – Brooksville, ME (completed grades 3-8) |
| <input type="checkbox"/> Junior High Retreat (currently in grades 6-8) | <input type="checkbox"/> Junior/Junior High Camp – Onset, MA (completed grades 3-8) |
| <input type="checkbox"/> Senior High Retreat (currently in grades 9-12) | <input type="checkbox"/> Junior High Camp – Brooksville, ME (completed grades 6-8) |
| | <input type="checkbox"/> Senior High Camp – Brooksville, ME (completed grades 9-12) |

Check registration status: Camper Counselor/Counselor-in-Training Staff

GENERAL INFORMATION

Name _____ Age _____ Date of Birth _____ Grade _____

Gender Female Male SS # _____ – _____ – _____ T-Shirt Size _____

Phone Number () _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Religious Affiliation _____ Home Church _____

Name of Parents, Custodial Parent or Legal Guardian* _____

Home Phone () _____ Work Phone () _____ E-mail _____

Additional Parent, Legal Guardian or Next of Kin* _____

Home Phone () _____ Work Phone () _____ E-mail _____

Persons allowed to pick up child from camp/retreat* _____

**Applies only to those under 21 years of age.*

EMERGENCY NOTIFICATION

Name _____ Relationship _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Name _____ Relationship _____ Phone () _____

Address _____ City _____ State _____ Zip _____

MEDICAL INFORMATION

Allergies to foods, medications Yes No If yes, please list _____

Is applicant currently under a physician's care for any acute or chronic medical condition? Yes No

 If yes, please explain _____

Does applicant require **nonprescription** medication on their person? Yes No

 If yes, list medications and purpose _____

Does applicant require **prescription** medication on their person? Yes No

 If yes, list medications and purpose _____

Name of Physician _____ Phone () _____

Health Insurance Provider _____ Phone () _____

Policy Holder's Name _____ Group No. _____ Policy No. _____

Address _____ City _____ State _____ Zip _____

Other information _____

Please attach a copy of both sides of your insurance card

HEALTH INFORMATION

Has applicant ever had any of the following? (Please check if yes and provide month and year of latest occurrence.)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Appendicitis _____ | <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Chicken Pox _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Frequent Colds _____ | <input type="checkbox"/> Heart Trouble _____ |
| <input type="checkbox"/> Heart Murmur _____ | <input type="checkbox"/> Fractures _____ | Describe _____ | |
| <input type="checkbox"/> HIV _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Kidney Trouble _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Scarlet Fever _____ |
| <input type="checkbox"/> Sinusitis _____ | <input type="checkbox"/> Sore Throats _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Whooping Cough _____ |

Please list applicant's major operations or serious injuries (describe and give dates)

Please list applicant's immunization dates for the following (or attach a copy of health card):

- | | | | |
|---------------------|--------------------------|-----------------------|----------------|
| DPT _____ | Booster Diphtheria _____ | Booster Tetanus _____ | Smallpox _____ |
| Typhoid _____ | Tuberculin _____ | Measles _____ | Mump[s] _____ |
| Polio Vaccine _____ | Other _____ | | |

What contagious disease(s) has the applicant been exposed to lately? _____

- Please check any of the following conditions that apply to the applicant. Vision Problems Hearing Problems Hernia
- Fainting Diarrhea Constipation Sleep Walking Bed Wetting
- Recent Emotional Upset — Death of loved one, divorce of parents. Please explain _____

Please describe any other medical, emotional, psychological, dietary, or physical conditions that could affect the applicant's experience at camp. _____

PERMISSION FOR MEDICAL TREATMENT (MUST BE SIGNED FOR YOUTH TO PARTICIPATE)

I, the undersigned parent, legal guardian, next of kin, or applicant, hereby authorize any necessary medical treatment for this applicant/myself. I also guarantee payment of all charges incurred during this medical treatment.

****Signature of Parent/Guardian/Applicant** _____ **Date** _____

PHOTO RELEASE (FOR PHOTOS USED IN CAMP LOG, YOUGH CALENDARS, ETC.)

In consideration of the right of the applicant to participate in this activity, I give consent to and authorize the taking of photographs or videotapes in which the applicant may appear. I waive all right of privacy in and to any said photographs or videotapes.

****Signature of Parent/Guardian/Applicant** _____ **Date** _____

ACTIVITY CONSENT (MUST BE SIGNED FOR YOUTH TO PARTICIPATE)

I specifically consent to the applicant's participation in activities offered by this camp/retreat, including but not limited to camping, boating, canoeing, swimming, hiking, water or snow skiing, and other sporting events. I have deleted any items from the preceding list to which I do **NOT** give consent for participation. I certify that the applicant has the necessary skills to participate in any of the approved activities (e.g., if boating is approved, the camper can swim). I specifically do **NOT** want the applicant to participate in the following activities:

****Signature of Parent/Guardian/Applicant** _____ **Date** _____

LIABILITY RELEASE (MUST BE SIGNED FOR YOUTH TO PARTICIPATE)

The undersigned parent, legal guardian, next of kin, or participant acknowledges that even though every effort is made to provide a safe, accident-free environment, incidents may occur. In consideration for being accepted by New England Mission Center of the Community of Christ for participation in this event, we (I), being 21 years of age or older, do for ourselves (myself) (and on behalf of my child-participant, if said child is not 21 years of age or older) hereby release forever, discharge, and agree to hold harmless the camp/retreat and the Community of Christ and the directors thereof from any and all liability, claims, or demands for personal injury, sickness, or death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in this event. Furthermore, we (I) (and on behalf of my child-participant, if under the age of 21 years) hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreating and work activities involved therein. Further, authorization and permission is given to said organization to furnish any necessary transportation, food, and lodging for this participant. The undersigned further agrees to hold harmless and indemnify said organization, its directors, employees, and agents, for any liability sustained by said organization as the result of negligent, willful, or intentional acts of said participant, including expenses incurred attendant thereto.

Both parents must sign unless parents are separated or divorced, in which case custodial parent must sign.

****Only applicant must sign if 21 years of age or older.**

****Signature of Parent/Guardian/Applicant** _____ **Date** _____

****Signature of Parent/Guardian/Applicant** _____ **Date** _____