



*Heartland Baptist Association*

# INTRODUCTION TO CAMPING (GRADES 1-3)

May 7 & 8, 2010

## 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 must have the forms and registration fees IN the Association Missions Center by the deadline date. Cabin Leader Fee \$30, Due Upon Registration - **Deadline is April 26, 2010.**

CAMP POSITION \_\_\_\_\_

Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Phone (        ) \_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_