



*Heartland Baptist Association*

**MISSION FRIENDS (Through 2<sup>nd</sup> Grade)  
YOUNGER CHILDREN'S CAMP  
July 23-26th, 2010**

**MISSION FRIENDS REGISTRATION FORM**

**(MUST BE COMPLETED BY PARENT OR GUARDIAN: NOT BY THE MISSION FRIEND)**

**Please use dark ink when completing this form and print clearly! 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. Camp Fee \$35, Due Upon Registration. **Deadline is July 6, 2010****

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

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ CHRISTIAN? Yes No CHURCH MEMBER? Yes No

CHURCH NAME & LOCATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**MISSION FRIENDS MEDICAL INFORMATION**

CHECK AND COMMENT ON ALL THAT APPLY:

ALLERGIES:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Penicillin         | <input type="checkbox"/> Bee/insect sting | <input type="checkbox"/> Sulfa/other drugs | <input type="checkbox"/> Poison Ivy      |
| <input type="checkbox"/> Sunburn easily     | <input type="checkbox"/> Tetanus shot     | <input type="checkbox"/> Hay fever         | <input type="checkbox"/> Aspirin/Tylenol |
| <input type="checkbox"/> Other (list) _____ |   |  |  |

HAS HISTORY OF/UNDER MEDICAL CARE FOR:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Heart trouble         | <input type="checkbox"/> Tonsillitis      | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Epilepsy/seizures     | <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Hernia                | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Other (Explain) _____ |   |  |  |

SUBJECT TO:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Homesickness       | <input type="checkbox"/> Cramps        | <input type="checkbox"/> Convulsions            | <input type="checkbox"/> Sore throat                 |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Nosebleeds    | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Sleepwalking                |
| <input type="checkbox"/> Exhaustion         | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Toothaches             | <input type="checkbox"/> Swimmer's ear               |
| <input type="checkbox"/> Hyperactivity      | <input type="checkbox"/> Bedwetting    | <input type="checkbox"/> Cold/pneumonia         | <input type="checkbox"/> Stomach/digestive disorders |
| <input type="checkbox"/> Afraid of the dark | <input type="checkbox"/> Moody periods | <input type="checkbox"/> Other (Explain): _____ |  |

**LIST ANY ACTIVITY THE CAMPER SHOULD NOT PARTICIPATE IN: \_\_\_\_\_**

*(The remainder of this form is found on the back of this page. Please complete all required information.)*

**MEDICATIONS REQUIRED WHILE AWAY FROM HOME. PLEASE LIST MEDICATION AND DOSAGE.**

Name of medication \_\_\_\_\_

For \_\_\_\_\_

Instructions \_\_\_\_\_

(All medications should be checked in with the camp nurse.)

ANY MEDICATIONS THAT SHOULD NOT BE GIVEN?

DATE OF LAST TETANUS SHOT \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OTHER SHOTS UP-TO-DATE? Yes No

FAMILY PHYSICIAN \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

NAME OF INSURANCE CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

**MEDICAL RELEASE:** I (we) have provided complete and accurate information about this camper on both Registration Form and Medical Information Form and understand that, in the event medical treatment is required, every effort will be made to contact me(us) or the other person named above. However, if I(we) cannot be reached, I(we) give permission to the staff or sponsor to secure the medical services deemed necessary to provide for this camper's well being. I(we) 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 supplement the family insurance. I(we) also understand that any or all of this information may be used by the Camp Director, Camp Nurse, or Cabin Leader. I (we) also have read the attached General Information Sheet and agree to its contents.

**BOTH PARENTS OR ALL LEGAL GUARDIANS MUST SIGN THIS FORM!**

**PARENTAL/GAURDIAN INFORMATION**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Please print

IS THE FOLLOWING ADDRESS THE SAME AS THE ABOVE NAMED CAMPER? YES NO

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Please print

IS THE FOLLOWING ADDRESS THE SAME AS THE ABOVE NAMED CAMPER? YES NO

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_