

Heartland Baptist Association
CAMP GROUND ZERO & Life
July 18-22, 2011

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 \$45, Due Upon Registration. **Deadline is June 23, 2011**

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:

_____ 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 _____ Skin disorder _____ Asthma
_____ Epilepsy/seizures _____ Appendicitis _____ Bronchitis _____ Diabetes
_____ Hernia _____ Nervous disorder _____ Athletes foot _____ Stomach ulcer
_____ Other (Explain) _____

SUBJECT TO:

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

Any medications that you CANNOT TAKE? _____

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 . Medication must be in original container.)

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 ____ / ____ / ____