



CAMP POSITION _____

Heartland Baptist Association

CAMP GROUND ZERO

ROOM ASSIGNED _____

July 18-22, 2011

CAMP STAFF/CABIN LEADER

REGISTRATION FORM

Please use **dark ink** when completing this form and **print** clearly! Turn this form, church recommendation 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 of JUNE 23, 2011.** Cabin Leader Fee \$90. Due Upon Registration. This includes your T-shirt and a snack shack ticket.

Please choose the size shirt you need:

(Adult Sizes only; Circle One) Small Medium Large X-Large XX-Large XXX-Large

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 _____

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 THAT CAMP LEADERSHIP SHOULD BE AWARE OF? 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 _____ CITY _____ STATE _____ ZIP _____

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) _____

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 and in the original container.)

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 also be used only to supplement the family insurance.

I HAVE ALSO READ AND UNDERSTOOD THE INFORMATION SHEET PROVIDED WITH THIS FORM AND AGREE TO ITS CONTENTS. LIKEWISE, I HAVE APPROVED THE BACKGROUND CHECK CONDUCTED BY MY CHURCH.

Signed _____

Date ____/____/____