



Heartland Baptist Association

INTRODUCTION TO CAMPING (GRADES 1-3)

May 6 & 7, 2011

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 \$35, Due Upon Registration - **Deadline is April 25, 2011.**

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 ____/____/____