# 2017 Mt. Cross Day Camp Registration Form

**Camper Name**_____ **Birth Date**_____ **Gender**_____

Home Address_____

Age _____ Grade (as of 9/2017) _____

City _____ State _____

Zip Code _____

Does Camper attend church? _____

If so, where? _____

Please print clearly in ink and use a separate form for each camper. The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. This form must be filled out by parents/guardians of minors. An update is required annually

**Parent or Guardian Name(s)** _____

Phone numbers where you can be reached during the day (please circle best number to call)

Home # _____ Work # _____

Cell # _____

Home Address (if different than camper address) _____

Email address _____

Emergency Contact (other than above) _____

Daytime Phone _____ Relationship to Camper _____

Parent/Guardian Authorization:

*I give Mt. Cross Ministries permission to use photography/video of myself/my child taken at Day Camp in the future promotion of Mt. Cross Ministries.*

Signature of parent/guardian or adult camper _____

Date _____

# 2017 Mt. Cross Day Camp Health Form

**Camper Name:** **Date of Birth:**

## **Allergies** *Please list all known allergies*

Medication Allergies _____

Describe reaction and management of reaction _____

_____

Food Allergies _____

Describe reaction and management of reaction _____

_____

Other Allergies _____

Describe reaction and management of reaction _____

_____

## Current Medications _____

Reason/s for taking _____

_____

## Medical Conditions

Does the camper have any medical conditions of which the Day Camp staff should be aware? Please use this space to describe.

_____

_____

_____

_____

## Restrictions *The following restrictions apply to this individual*

Please explain any activity restrictions (i.e. what cannot be done, & what adaptations or limitations are necessary)

_____

_____

_____

# 2017 Mt. Cross Day Camp
# Health Form

## Additional information

Please use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the Day Camp staff should be aware. *The better informed the Day Camp staff can be, the better they will be able to provide for the needs of your child.*

_____

_____

_____

_____

Family Doctor _____ Phone _____

Address _____

City _____ State _____ Zip _____

Family Dentist/Orthodontist _____ Phone _____

Address _____

City _____ State _____ Zip _____

Is camper covered by medical/hospital insurance? Yes_____ No _____

If yes, please indicate carrier plan or name _____

Group Number _____

## Parent/Guardian Authorization:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all Day Camp activities except as noted.

I hereby give permission to the Day Camp staff to provide routine health care and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for medical treatment, referral, billing or insurance purposes. I give permission to the Day Camp staff to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian or adult camper _____ Date _____

Printed Name _____

Click here to submit form and email to the Youth Director at Faith Lutheran Church of Castro Valley