



# REGISTRATION AND HEALTH CARE CONSENT

PLEASE PRINT CLEARLY – REGISTER ONLY ONE CAMPER FOR ONE CAMP PER FORM

ALL GIRLS    ALL BOYS    JUNIOR CAMP    TEEN CAMP    SENIOR CAMP



Print and Mail Registration to: Camp Registrar P.O. Box 339 Wrightwood CA 92397 or E-mail PDF Form to registrar@verdugopines.org

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ PRESENT AGE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_  MALE    FEMALE   GRADE IN FALL \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PARENT OR GUARDIANS NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ CELL PHONE \_\_\_\_\_

ALTERNATE PERSON: \_\_\_\_\_ PHONE \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ CELL PHONE \_\_\_\_\_

CHURCH / GROUP I ATTEND \_\_\_\_\_

I UNDERSTAND AND AGREE TO ABIDE WITH THE RESTRICTIONS PLACED ON MY CAMP ACTIVITIES.

SIGNATURE OF CAMPER \_\_\_\_\_ DATE \_\_\_\_\_

MY CHILD WILL BE PICKED UP BY \_\_\_\_\_ PHONE \_\_\_\_\_

NAME & DATE OF CAMP \_\_\_\_\_ CAMP DATE \_\_\_\_\_

IF POSSIBLE PLEASE PLACE ME IN THE SAME CABIN AS: (ONE FRIEND ONLY) \_\_\_\_\_

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

MEDICAL TREATMENT WITHIN THE PAST YEAR: \_\_\_\_\_

- BLEEDING / CLOTTING    HYPERTENSION    MONONUCLEOSIS    HEART CONDITION    EYE, EAR, NOSE, THROAT
- DIABETES    ASTHMA    CONVULSIONS / SEIZURES    TUBERCULOSIS    ATHLETES FOOT    CHICKEN POX

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

ALLERGIES: (INCLUDE PENICILLIN) \_\_\_\_\_

SPECIAL MEDICATION / DIET: (ATTACH INSTRUCTIONS OF MD) \_\_\_\_\_

LIMITATIONS TO ACTIVITIES: \_\_\_\_\_

LIST DISABILITIES: \_\_\_\_\_

SPECIAL NEEDS / OTHER: \_\_\_\_\_

THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED AS, \_\_\_\_\_ HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED IN WRITING. AUTHORIZATION FOR TREATMENT: I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR OF SOUTHERN CALIFORNIA BIBLE CONFERENCE, TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT; TO RELEASE ANY RECORDS NECESSARY FOR INSURANCE PURPOSES; AND TO PROVIDE OR ARRANGE NECESSARY RELATED TRANSPORTATION FOR ME/OR MY CHILD IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY. I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION FOR THE PERSON NAMED ABOVE. THE COMPLETED FORMS MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP. I ALSO UNDERSTAND MY CHILD'S PHOTO MAY BE TAKEN AT CAMP. I AUTHORIZE VERDUGO PINES BIBLE CAMP TO USE THESE PHOTOS FOR CAMPER ENJOYMENT OR PROMOTIONAL PURPOSES. THIS AUTHORIZATION SHALL REMAIN EFFECTIVE UNLESS REVOKED IN WRITING.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_ DATE \_\_\_\_\_

RULES FOR ACCEPTANCE AND PARTICIPATION IN THE PROGRAMS ARE THE SAME FOR EVERYONE WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, AGE, SEX, OR HANDICAP.

### FOR REGISTRAR'S USES ONLY

SUMMARY	
COST .....	\$ _____
DISCOUNT .....	\$ _____
ENCLOSED .....	\$ _____
SPONSOR .....	\$ _____
.....	
SCHOLARSHIP .....	\$ _____
.....	
ELECTRONIC FEE .....	\$ _____
AMOUNT DUE .....	\$ _____
.....	

----- DATE REGISTRATION RECEIVED -----
----- DATE CONFIRMATION SENT -----
----- CHARGE APPROVAL NUMBER -----
<b>PAID IN FULL</b>

DEPOSIT	
<input type="checkbox"/> AMOUNT \$ _____	
<input type="checkbox"/> CASH _____	
<input type="checkbox"/> CHECK # _____	
<input type="checkbox"/> CHARGE _____	
BALANCE PAID	
<input type="checkbox"/> AMOUNT \$ _____	
<input type="checkbox"/> CASH _____	
<input type="checkbox"/> CHECK # _____	
<input type="checkbox"/> CHARGE _____	