Section-1 **REGISTRATION FORM**

Please complete all three sections of this application. Circle the week you are applying for (one week per form). Include $15 deposit for each application along with copy of health insurance, Medicaid or Military ID. **Do not send cash.**

June 6-11 **Grades 10-12**	**June 13-18** **Grades 7-9**	**June 20-25** **Grades 5&6**	**June 27-July 2** **Grades 3&4**	**July 4-9** **Grades 1&2**	**July 11-16** **Grades 7-9**	**July 18-23** **Grades 5&6**	**July 25-30** **Grades 3&4**

Name: _____ _ _____
(Last) (First) (Middle) (Name called at home)

Address: _____
(Number and Street or P.O. Box) (City) (State) (Zip)

Email: _____ Home Phone_____Parent's Work Phone: (Father) _____ (Mother) _____
(Or Cell Number)

Father's Name: _____ Mother's Name: _____ Guardian_____

Child's Gender: Boy_____ Girl_____ Camper's Age: _____ School Grade Now Completing _____

Home Church & Address: _____ Is Child A Member? _____yes or _____no

APPLICANT NOT TO WRITE IN THESE BOXES – CAMP USE ONLY:

Date Received	Confirm Date	Deposit Paid	Balance Owed	Cabin Assigned	Received By	Balance Received
						Cash _____ Check _____ Mail _____

Section -2 **PLEASE COMPLETE - EALTH CARD - FOR NURSE'S USE - WEEK OF_____ _____**

Name: _____ _____
(Last) (First) (Middle) (Name called at home)

Address: _____
(Number and Street or P.O. Box) (City) (State) (Zip)

Home Phone: _____ Parent's Work Phone (Father) _____ _____ (Mother) _____
(Or Cell Number)

PLEASE CIRCLE YES OR NO AND EXPLAIN AS NEEDED BELOW:

Does the camper have allergies? Yes or No If so, list & explain_____

Does camper have any serious medical problems? Yes or No If so, explain_____

Will camper need special medication or treatment at camp? Yes or No If so, explain_____

_____

Is camper prohibited from any activities? Yes or No If so, explain_____

_____

Are camper's immunizations current? Yes or No Date of last Tetanus shot _____

Has camper had Chicken Pox? Yes o r No been vaccinated? Yes o r No

Do you grant the nurse permission to treat camper with over-the-counter medications for minor complaints or injuries Yes or No

In an emergency, if we are unable to contact you or your doctor, do we have permission to use the on-call doctor and nearest hospital? Yes or No

Family Doctor's Name & Address:_____ Phone Number_____

Additional information the nurse needs to know: _____

(Cabin Assign _____ _____) **Parent or Guardian Signature _____**
do not write here **(Please enclosed copy of insurance card, Medicaid or Military ID)**

Section -3 **PLEASE COMPLETE - CABIN CARD –FOR COUNSELOR'S USE - WEEK OF _____**

Name: _____ Boy_____ Girl_____
(Last) (First) (Middle) (Name called at home)

Address: _____ Age_____ Grade Completed_____

Home Phone: _____ Parent's Work Phone (Father) _____ (Mother) _____
Or Cell Number

Home Church & Address: _____ Member? Yes_____ or No_____

Is camper prohibited from: Swimming _____ or Diving_____ Other Activities_____?

Any special dietary or medical requirements? Yes or No If so, explain_____

Is camper given to any of these items? (Please Circle) bed wetting sleep walking night terrors fainting sore throats

Additional information for cabin leader : _____

APPLICANT NOT TO WRITE BELOW THIS LINE!

Nurse's Notes to Counselor:	Director's Notes to Counselor:
Cabin Assignment	Counselor's report or additional space for Nurse/Director

ATTENTION FLORIDA CAMPERS: IF YOUR ENDING SCHOOL YEAR CONFLICTS WITH YOUR WEEK OF CAMP, PLEASE PHONE US OR EMAIL US BEFORE SUBMITTING AN APPLICATION.