

ARROWS CAMP 2018 REGISTRATION FORM

Please include the following for registration (one child per form):

Name: _____ MI _____ Age:(On 1st day of camp) _____ Birth Date: ____ \ ____ \ ____

Parent's/ Guardian's name: _____ E-mail Address _____

Address: _____ Zip Code: _____

Home phone:(____) _____ Other phone:(____) _____ Congregation: _____

Non-Parent Emergency contact: _____ Address: _____

Emergency contact's home phone:(____) _____ Other phone:(____) _____

Acceptance letters will be sent within 3 weeks after receiving your application. How may we send it to you? E-Mail__ Snail Mail__

HEALTH INFORMATION

Operations or serious injuries (dates): _____

Disability or chronic or recurring illness: _____

Physical, emotional or mental handicaps: _____

Activities encouraged or limited by physician: _____

Dietary modifications: _____

Current medication (send with instructions): _____

Other diseases or details of above: _____

Name of family physician: _____ Phone: _____

Suggestions on health related information for camp personnel: _____

May we call you after 10:00pm if your child is homesick? Yes__ No__

HEALTH HISTORY (Check all that apply and give approximate date)

Frequent Ear Infections _____ Heart Defect/ Disease _____ Seizures _____

Diabetes _____ Bleeding/Clotting Disorders _____ Hypertension _____

Mononucleosis _____ Psychiatric Treatment _____ Recent Head Lice Infestation _____

Frequent Sore Throat _____ Stomach Upsets _____ Bed Wetting _____

Sleepwalking _____

DISEASES:

Chicken Pox: _____ Measles: _____ German Measles: _____ Mumps: _____

ALLERGIES (date not needed):

Hay fever: _____ Ivy Poisoning, etc. _____

Insect Stings (how severe): _____ Asthma: _____ Penicillin: _____

Other Drugs: _____ Other (specify): _____

My child has had a tetanus shot within the last ten years. (yes or no)

If not, I am aware of the risks and am responsible for costs if necessary to get a shot during camp.

This health history is correct so far as we (I) know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for treatment: In the event we (I) cannot be reached in an emergency, we (I) hereby give permission to the medical personnel selected by Keystone Camp personnel to secure and administer treatment including X-rays, routine tests, hospitalization, and necessary related transportation for my child. We (I) hereby release and covenant with **Promised Land Camp** and **Keystone Mennonite Fellowship** that we(I) will never, individually or as legal guardians of said individuals, institute any action at law or in equity for any personal injuries, or injuries to property, real or personal, caused by, or arising out of, camping and other related activities sponsored by **Promised Land Camp** and **Keystone Mennonite Fellowship**, its successors and legal representatives.

Signature of parents or guardian: Father _____ Mother _____

____ I have enclosed my \$50 non-refundable registration fee with this form; I will pay the balance at camp.

____ I have enclosed a total of \$190 which includes my \$50 non-refundable registration fee and \$140 for the week of camp.

____ I have enclosed an additional \$ _____ as a donation for the camp.

Roommate preference of one person is considered only when mutually requested. _____

(If more than one name is listed, none of the names will be considered.)

Send completed form to: Brian & Margaret Martin, 522 Fivepointville Rd, Denver, PA 17517

Make checks payable to: Keystone Mennonite Fellowship.