

# ARROWS CAMP 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 \$205 which includes my \$50 non-refundable registration fee and \$150 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.)**

**Registration questions, contact Brian and Sherina Sensenig**

**[kcregistration@hotmail.com](mailto:kcregistration@hotmail.com)**