

**2009 High School Camp Registration Form**  
**WITH ALL YOUR HEART, SOUL & MIGHT August 2<sup>nd</sup> to August 8<sup>th</sup>**

*Sponsored by Cornerstone Trinity Baptist Church*

Early Deadline: July 5<sup>th</sup> ..... \$340  
 Regular Deadline: July 19<sup>th</sup> ..... \$365

Please make checks payable to **Cornerstone Trinity Baptist Church**  
 (No cash accepted)

Personal Information				
Name:			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 2009 <input type="checkbox"/> 2010
				<input type="checkbox"/> 2011 <input type="checkbox"/> 2012
Address:	Street Address			Cross Street
	City	State	Zip Code	
Birth Date:	Home Phone: ( )	Cell Phone: ( )		
<input type="checkbox"/> Please check this box and complete the fields below if your child needs to be driven home to an address that is different from the one listed above.				
Address:	Street Address			Cross Street
	City	State	Zip Code	

Emergency Contact Information			
Name:		Relationship to Camper:	
Work Phone:	( )	Alternate/Cell Phone:	( )

Medical Information	
Medical Insurance Company:	
Policy/Subscriber #	<input type="checkbox"/> No Medical Coverage
Allergies:	Please list any allergies your child may have. If none, write none:
Medication:	Please allow my child to take the following medication, i.e. Ibuprofen, allergy medicine:
Other Medical Information:	Please list any other medical conditions that your child may have:

Other Information	
Parent/Guardian email address for confirmation of registration & camp information:	@

**Parent/Guardian Agreement**

**PLEASE INITIAL:**

\_\_\_ I hereby give permission for the above child to attend camp at Koinonia Conference Grounds and to participate in all activities including the No Fear Zone's high and low ropes course if available.

\_\_\_ **I will not hold Koinonia Conference Grounds or its agents liable for injury caused by common accident, illness or the rendering of emergency care.**

\_\_\_ **I hereby release Cornerstone Trinity Baptist Church ("CTBC"), its officers, directors, employees, members, volunteers, and agents of and from any and all actions, suits, proceedings, claims, demands, assessments, judgments, damages, deficiencies, liens, penalties, fines, costs and expenses, including reasonable attorneys' fees, resulting from, based upon, or arising out of any activity, accident or injury occurring at the Camp or en route to the Camp or en route from the Camp.**

\_\_\_ I assume responsibility for my Child's behavior in adhering to all Rules of Conduct and Regulations of the Camp. If, at the Director's discretion, it is decided that the Child is unable to continue respectfully in our Camp, no refund will be given.

\_\_\_ I give permission for Koinonia Conference Grounds and Cornerstone Trinity Baptist Church to use any pictures or video taken of my child for future promotional use.

\_\_\_ The information provided on this form is true and correct.

**Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

The following information is requested to comply with recent California laws and regulations governing the operation of organized camps. The purpose of the information is to provide a safe environment for your child and all other camp attendees. All information will be kept confidential by Cornerstone Trinity Baptist Church and Koinonia Conference Grounds and will be disclosed only to the extent required by law.

**HEALTH HISTORY:** To be completed and signed by parent or guardian. Please keep a copy for your records and to record changes in your child's health status. Please notify Koinonia Conference Grounds in writing if there are any changes.

**ALLERGIES:** Please mark those that apply to this camper:

This camper has no known allergies.

This camper has an allergy to the following food(s): \_\_\_\_\_

Does this cause anaphylaxis?  Yes  No  Unknown

Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed):  
\_\_\_\_\_

**NUTRITION:** We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to this camper. Please call if you have any questions.

This camper eats a regular, varied diet

This camper is lactose-intolerant. (Our expectation is that the camper will bring his/her own supply of products (such as Lactaid) and will contact the camp nurse when the supplement is needed.)

**CHRONIC CONCERNS:** Please mark all that pertain to this camper and provide information about supportive health care:

This camper has no chronic health concerns and is capable of full participation in this program.

This camper has the following chronic health concern(s):

Asthma

Headaches

Sleepwalking

Diabetes

Hearing Difficulties

Menstrual Cramps

Frequent ear infections

Bedwetting

Bee Sting Allergy

Seizure Disorder

Surgical History

Fainting

Fears/Phobias

Other (please describe): \_\_\_\_\_

Please provide information about supportive health care needed for each marked item (if any): \_\_\_\_\_

If *Surgical History* is marked above, please explain: *Date of Surgery:* \_\_\_\_\_ *Type of surgery:* \_\_\_\_\_

Are all symptoms resolved?  Yes  No - Please explain: \_\_\_\_\_

**MEDICATIONS:** All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes.

This camper does not take any medication

This camper takes daily medication:

Medication: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_

Dose Taken: \_\_\_\_\_

How often each day? \_\_\_\_\_

**MEDICATIONS (continued):**

The following medications, stocked in the Gauze Pad/Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used. Please cross-out any medicine your camper **should not** be given:

Acetaminophen (Tylenol)

Aloe

Antacid

Bismuth Chewable Tablets

Calamine Lotion

Chamomile Tea

Cough Drops

Diphenhydramine (Benadryl)

Dramamine

Guaifenesin DM (Cough Med)

Hydrocortisone Cream

Ibuprofen (Motrin)

Insect Repellent

Iodine Swabs

Kaopectate/Anti-Diarrheals

Nix

Pepto Bismol

Pseudoephedrine

Tinactin

Triple Antibiotic Cream

**Is the camper cleared by parent and physician for active camp participation?**  Yes  No

List record of immunizations: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

Camper's Physician Name: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**WHAT HAVE WE FORGOTTEN TO ASK?** Please provide additional information about your child's health which may have been neglected on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our active camp program.