2017 Staff Camper Registration Form

Twin Rivers Baptist Association

Read, complete fully (Print or Type) **Sign, Date** and return to

Twin Rivers Baptist Association
100 Twin Rivers Lane
Wright City, MO 63390

Associational Use Only
Date Received_____
Amount Paid_____
Check #_____

Camp Derricotte

Check Week Attending

❒Girl's Camp: July 10-14 ❒Youth Camp: July 14-16 ❒Boys Camp: July 17-21 *18 and older $0, age 16-17 $5 and 15 years old $10 Fees for staff*

Name _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Cell Phone Number _____

Are you a Christian?_____ Active member of what church?_____

T-Shirt Size (Adult sizes) ❒S ❒M ❒L ❒XL ❒XXL

Age_____ Date of Birth _____ Sex_____

Spouse / Parent Name_____ Phone_____

Contact Other Than Spouse / Parent_____ Phone_____

HEALTH AND EMERGENCY INFORMATION

Insurance Provider_____ Policy #_____

Doctor's Name _____ Phone_____

HEALTH HISTORY ❒Asthma ❒Seizures ❒Heart Problems ❒Diabetes ❒Frequent Headaches

I give permission for the nurse to administer the following over-the counter medicines orally as needed (check all that apply)

❒Tylenol (Pain) ❒Advil (Injury) ❒Ibuprofen ❒Benadryl (Allergy/Sinus) ❒Antacid (Upset Stomach)

Allergies (reactions to foods, drugs, insects, plants) _____

DATE of last Tetanus Shot _____

Medical Conditions (Explain) _____

Medicine Currently Taking _____

Should Your Physical Activities Be Restricted In Any Way? _____

NOTIFY THE NURSE If you have been treated for or comes in contact with any known infections/communicable diseases within the four (4) weeks prior to camp.

PRESCRIPTION MEDICINE: If you require medication during camp, make sure your name and the instructions are clearly marked on the prescription bottle (FROM THE PHARMACY). Take it to the nurse and fill out the Individual Record of Medication when checking in.

AUTHORIZATION For Staffers Under Age 18 : If a medical, accident or illness should arise and I cannot be contacted. I hereby give my permission to the Camp Director to select a physician and/or hospital for my child's care. **I understand my child will be transported by ambulance.** I hereby also give the physician and/or hospital my permission to hospitalize, treat and order injections or surgery for my child named herein, as needed.

If there is any change in the above information before camp begins. NOTIFY the Camp Director. I have read the camp rules in the Associational Camp Information and Guideline Booklet and I agree to abide by these guidelines as printed. I will engage in all supervised activities including swimming and field trips.

TO MY KNOWLEDGE THIS INFORMATION IS CURRENT AND UP TO DATE

Staff Members Signature_____ Date_____

Signed by Parent/Guardian _____ Date_____

STAFF PLEDGE

I understand that the way I dress can have an effect on my witness. I will adhere to the follows:

1. I will wear long pants, jeans, or MODEST length shorts (NO short shorts)
2. I will only wear shirts WITH sleeves.
3. I will make sure that my swimsuit is covered and wear a shirt to the pool.
4. I will wear appropriate shoes-- sandals to the pool, tennis shoes the rest of the time.

I understand that when I am at camp, I have the opportunity to grow in wisdom and grace and the knowledge of Christ. In order to make the best use of the opportunity, I will leave at home anything that could distract me (I pods, MP3, CD players, electronic games, cell phones, etc.)

I understand that my actions and words should be pleasing in the eyes of the Lord. I will do my best to show respect for all I meet this week.

I have written out and attached my testimony to this form.

I HAVE READ the camp information and guidelines booklet and I pledge to be a blessing as well as receive a blessing.

Signature of Staff_____ Date_____

Recommendations of Pastor _____ Church:_____
Pastors Signature

AUTHORIZATION FOR ACCESS TO BACKGROUND & CREDIT HISTORY

The undersigned hereby authorizes the Missouri Baptist Convention to review and obtain from any credit or consumer-reporting agency any and all records, documents or other information concerning my background and credit history including but not limited to my criminal background, creditworthiness, credit standing, credit capacity, characteristics or mode of living used in establishing my eligibility for employment. A Photo static copy of this authorization shall be considered as effective and valid as the original.

_____

Name (Last) First Middle

_____

Address City State Zip

_____

Date of Birth Social Security Number

_____

Signature Date

Medication Orders

Last Name____________________

Completed Form Must be on File For All Medication. Please turn in with Camper Registration

Medication	Time	S	M	T	W	T	F	Remarks

Campers Name____Cabin__________________________

Allergies____

Parent/Guardian______________________________________Emergency Phone Number______________________

All medicine must be sent in original container with dosage instructions and reason medication is needed. Only send enough for the days of camp.

Camper is responsible to collect medicine/container from the nurse at the end of camp.

Medicine Returned to Camper_____________________________

Nurses Signature____

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