Make check payable to: **Twin Rivers Baptist Association**

2017 Camper Registration Form

Twin Rivers Baptist Association

Read completely (Print or Type) **Sign, Date** and return with fee to:

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

Associational Use Only
Date Received_______
Amount Paid________
Check #___________

Check Week Attending

Camp Loutre Valley
❒ Girl's Camp: June 19-23 Pre-Reg.$60 Reg. @ Camp $70
❒ Boy's Camp: June26-30 Pre-Reg. $60 Reg.@ Camp $70
❒ Youth Camp: July 10-14 Pre-Reg. $60 Reg.@ Camp $70

Camp Fee nonrefundable after June 6, 2017

Name ____

Address___________________________ City ______________ State__________ Zip ________

School Grade (Fall 2016) ______________________ T-Shirt Size (**Adult sizes**) ❒S ❒ M ❒ L ❒XL ❒XXL

Age__________ Date of Birth ______________________ Sex____________

Registering with which Church___________________________ City________________

Father/Guardian Name___________________________ Phone________________

Father/Guardian Employer ___________________________ Phone________________

Mother/Guardian Name ___________________________ Phone________________

Mother/Guardian Employer ___________________________ Phone________________

Contact Other Than Parent ___________________________ Phone________________

HEALTH AND EMERGENCY INFORMATION

Insurance Provider___________________________ Policy #________________

Doctor's Name ___________________________ Phone________________

HEALTH HISTORY

Check ALL That apply

❒Asthma ❒Seizures ❒Heart Problems ❒Diabetes ❒Upset Stomach ❒Frequent Headaches

❒Bedwetting ❒Fainting ❒Diarrhea ❒Cramping ❒Emotional Difficulties ❒Hyperactive (On Medication)

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) ___________________________

Should Your Child's Physical Activities Be Restricted In Any Way? ___________________________

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

PRESCRIPTION MEDICINE: Parents, if your child requires medication during camp, make sure the camper's 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: 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. My child and I have read the camp rules in the Associational Camp Information and Guideline Booklet and we agree to abide by these guidelines as printed. I give permission unless otherwise noted, for my child to engage in all supervised activities including swimming and field trips.

Signed by Parent/Guardian ___________________________ Date________________

CAMPER PLEDGE

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

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

Signature of Camper ______________________________Date________

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I give permission for my child ___________________________________

to attend Activities with Camp Directors and Adult Supervisors away from

Loutre valley Camp the week of ____________________________.

Parent / Guardian 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_________________________________