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 Loutre Valley

Check Week Attending

☐ Girls Camp: June 19-23 ☐ Boys Camp June 26–30 ☐ Youth Camp: July 10-14

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

Signature of Staff______________________________ Date________

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