

Camp Dates: June 26-30, 2017

APPLICATION DUE BY: 6/5/2017

EMERGENCY NUMBERS:

Junior Camp (7 years old to 13 years old) Name: _____ Home () _____
Name: _____ Work () _____
CABIN BUDDY (MUST BE LISTED BY Name: _____ Other () _____
BOTH CAMPERS): _____

CAMPER HEALTH FORM
Michigan State Association of Free Will Baptists

Child's Name: _____
Last _____ First _____ Middle _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Birth date: ____/____/____ Age: ____ Grade Completed ____

Sex: ____ Church: _____ Parent or Guardian: _____

HEALTH HISTORY:

Drug Reactions: _____

Other Allergies/Reactions: _____

Special Diet: _____

Special Health/Behavior Needs/Physical Limitations: _____

Please Perform Head Lice Inspection Before Arrival At Camp!! Yes (Must Be Circled)

Current or Recent Exposure to Contagious/Infectious Disease: _____

My child has been immunized against the following in accordance with H.E.W. standards: Polio, Whooping Cough, Measles, Mumps, Rubella, Tetanus, and Diphtheria. Yes ____ No ____ Exceptions, please list: _____

Date of last Tetanus _____

MEDICATIONS:

Drug	Purpose	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

***All prescribed medications shall be labeled with licensed pharmacy and name of pharmacy, name of camper,**

*** Name and strength of medication, directions for use, and name of doctor prescribing medication.**

***It should be in its original container and placed in a zip lock bag with name, strength and directions of use written on the outside of the bag or medicine will not be distributed.**

***Do NOT put more than 1 medication in a container.**

*** SEND TWO DRUGS/ KITS IF DOCTOR ORDERS MEDICATION TO STAY WITH CHILD(i.e., emergency inhaler/bee sting kit).**

RESTRICTIONS:

Any activity restrictions (swimming, exercise, etc.) Yes ____ No ____

If answered yes, please describe restrictions.

INSURANCE INFORMATION:

Family Medical Insurance Carrier _____ Policy Number _____ Phone Number _____

FAMILY DOCTOR:

Family Doctor's Name: _____ Phone No.: () _____

PASTOR'S SIGNATURE: _____

(The Pastor's signature is **REQUIRED** for admission to camp.)

PLEASE COMPLETE BACK

CONSENT FOR MEDICAL TREATMENT (CAMPER)

I hereby give consent in advance to the Camp Director, Program Director or Camp Health Officer of Michigan State Association of Free Will Baptists and to the physicians or hospital selected by them to render first aid treatment, as in their judgment, is reasonably necessary, but not limited to: hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions and medications, anesthesia, and surgery for _____ (Child's Name). I understand that the Camp Director, Program Director, or Camp Health Officer will attempt to contact me before securing medical treatment, but that this consent is given in the event I am not available in an emergency. I release the Michigan State Association of Free Will Baptist Camp leaders and staff from any and all claims, loss, cost, damage or expense arising out of or from any accident or other occurrences causing injury to any person or property.

Signature of Parent/Guardian (MUST BE SIGNED)

Date

CHILD RELEASE FORM

Person(s) authorized to take my child from camp: _____

Address City State Zip

Phone (____) _____ Child may **NOT** GO home with _____

Signature of Parent/Guardian

IF LEAVING EARLY _____ will be picked up on _____
Name of camper Date/Day

By _____ at _____
Name/Relationship Time

Again for 2017, Family plan pricing: First child-\$135; Second child-\$110; \$85 per child thereafter. Checks should be made payable to your local church. Send one church check for all campers fees payable to Michigan State Association of Free Will Baptists. Please mail completed application and camp fees to:

**Michigan FWB Youth Camp
64395 Romeo Plank Road
Ray, MI 48096**

**Camp Directors
Gordie Rohroff (810) 937-9048**

Kim Rohroff (810) 937-9058