



CAMP POSITION \_\_\_\_\_

*Heartland Baptist Association*

**CAMP LIFE**

ROOM ASSIGNED \_\_\_\_\_

May 29 – June 2, 2018

**CAMP STAFF/CABIN LEADER**

**REGISTRATION FORM**

Please use **dark ink** when completing this form and **print clearly!** Turn this form, church recommendation form and registration fee in to your church. The church must have the forms and registration fees **IN the Association's Mission Center by the Deadline Date of May 3, 2018.** Staff/Cabin Leader Fee \$58. Due Upon Registration. This includes your T-shirt and a snack shack ticket.

**Please choose the size shirt you need:**

(Adult Sizes only; Circle One) Small Medium Large X-Large XX-Large XXX-Large

NAME \_\_\_\_\_ M \_\_\_ F \_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ CHRISTIAN? Yes No CHURCH MEMBER? Yes No

CHURCH NAME & LOCATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HAVE YOU EVER SERVED IN CAMP BEFORE? \_\_\_\_\_ IF SO IN WHAT POSITIONS?  
\_\_\_\_\_

HAVE YOU EVER BEEN FORMALLY CHARGED WITH CHILD ABUSE, SEXUAL ABUSE OR ASSAULT OR ANY OTHER CRIMINAL OFFENSE THAT CAMP LEADERSHIP SHOULD BE AWARE OF? Yes No

If yes, explain \_\_\_\_\_

ARE THERE ANY ACTIVITIES IN WHICH YOU COULD NOT HELP OR PARTICIPATE? (Explain)

\_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

**WE DO APPRECIATE YOUR GIVING THIS WEEKEND TO HELP  
CHANGE THE LIVES OF SOME YOUNG PEOPLE.**

**Medical Form on the backside of this page must be completed and signed.  
STAFF/CABIN LEADER MEDICAL INFORMATION**

NAME \_\_\_\_\_

**CHECK AND COMMENT ON ALL THAT APPLY:**

**ALLERGIES:**

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bee/insect sting	<input type="checkbox"/> Sulfa/other drugs	<input type="checkbox"/> Poison Ivy
<input type="checkbox"/> Sunburn easily	<input type="checkbox"/> Tetanus shot	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Aspirin/Tylenol
<input type="checkbox"/> Other (list) _____	_____		

**HAS HISTORY OF/UNDER MEDICAL CARE FOR:**

<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Athletes foot	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Skin disorder
<input type="checkbox"/> Other (Explain) _____	_____		

**SUBJECT TO:**

<input type="checkbox"/> Cramps	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Headaches
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Earaches	<input type="checkbox"/> Fainting	<input type="checkbox"/> Toothaches
<input type="checkbox"/> Swimmer's ear	<input type="checkbox"/> Cold/pneumonia	<input type="checkbox"/> Stomach/digestive disorders	
<input type="checkbox"/> Other (Explain) _____	_____		

**MEDICATIONS REQUIRED WHILE AWAY FROM HOME**

Name of Medication \_\_\_\_\_

For \_\_\_\_\_

Instructions \_\_\_\_\_

(All medications should be checked in with the camp nurse and in the original container.)

Any medications that you CANNOT TAKE? \_\_\_\_\_  
(aspirin, cough drop, etc.)

FAMILY PHYSICIAN \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

NAME OF INSURANCE CARRIER \_\_\_\_\_

POLICY # \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_

**MEDICAL RELEASE:** I have provided complete and accurate information about myself and understand that, in the event medical treatment is required, and I cannot speak for myself, every effort will be made to contact the person listed in case of emergencies. However, if they cannot be reached & I cannot give my permission, permission is given to the staff to secure the medical services deemed necessary to provide for my well being. I also understand that the insurance provided by Grand Oaks Baptist Assembly, Inc. is a limited supplemental policy covering only injury or accidents occurring during the event at Grand Oaks, and will also be used only to supplement the family insurance.

**I HAVE ALSO READ AND UNDERSTOOD THE INFORMATION SHEET PROVIDED WITH THIS FORM AND AGREE TO ITS CONTENTS. LIKEWISE, I HAVE APPROVED THE BACKGROUND CHECK CONDUCTED BY MY CHURCH.**

Signed \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_