

# MASTER'S CAMP

## \* Sponsor Registration/Medical Information \*

I promise to obey the rules and regulations of Alto Frio Baptist Encampment and will cooperate with the leaders and fellow campers.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthday \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you a Christian? \_\_\_\_\_ Church Membership \_\_\_\_\_

What church are you coming to camp with? \_\_\_\_\_

**Circle T-Shirt size**   **XXL**   **XL**   **Lrg**   **Med**   **Sm**

**Camper's Signature** \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number (\_\_\_\_) \_\_\_\_\_ Business Phone Number (\_\_\_\_) \_\_\_\_\_

Family Physician's Name \_\_\_\_\_ Phone number \_\_\_\_\_

Name of primary insurance policy \_\_\_\_\_ Policy number \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_ Is camper allergic to Tetanus booster? \_\_\_\_\_

Date of Oral Polio Vaccine \_\_\_\_\_ Date of Measles/Mumps/Rubella Vaccine \_\_\_\_\_

### Has camper had:

Appendix removed? \_\_\_

Chickenpox? \_\_\_

Fainting spells? \_\_\_

Asthma? I: \_\_\_

Heart trouble? \_\_\_

Convulsions? \_\_\_

Diabetes? \_\_\_

Allergies to food or medicine? \_\_\_\_\_

Specify \_\_\_\_\_

Allergies to bites or stings? \_\_\_\_\_

Specify \_\_\_\_\_

Any other allergies? \_

Specify \_\_\_\_\_

### Medication Authorization

Is Camper taking any medication that must be given at camp? \_\_\_\_\_

If Yes please complete the following

Please Administer to \_\_\_\_\_

The Following medications \_\_\_\_\_

Dosage: \_\_\_\_\_

Time: \_\_\_\_\_

Date of Camp \_\_\_\_\_

Signature \_\_\_\_\_

In consideration for your agreeing to accept the above named individual as a camper, I hereby give my authority and consent to medical and surgical treatment as may be needed in the judgment of the treating physician chosen by the Alto Frio Administrator or his representative. I understand the twenty-four (24) hour first aid station is available. I further understand that limited secondary accident and illness coverage is provided.

SponsorsSignature \_\_\_\_\_

Other person to notify in case of emergency: Name \_\_\_\_\_

Phone \_\_\_\_\_