2022 REGISTRATION FORM

Please complete both sides. Registration deadline is the Wednesday before the first day of the camp you plan to attend.

Enclose payment by credit card or check payable to Baptist Camp 1. Detach this page from brochure. Lebanon, **OR** enclose the MINIMUM \$100 non-refundable deposit. 2. COMPLETE ALL INFORMATION on both sides (registration Balance due **ON** registration day. form AND health form). Parent/Guardian signature is REQUIRED. NOTE: Form will be returned if incomplete or not signed in both 5. Mail to: Registrar, Baptist Camp Lebanon places by parent/guardian. Campers are registered by GRADE 79 Blossom Hill Road COMPLETED as of the end of JUNE 2022, NOT BY AGE LEVELS. Lebanon, NJ 08833 3. Pastor's signature **REQUIRED** when receiving church campership. Camp Name From: Camper's Last Name First Birth Date Age in June Grade Completed in June 2022 Street Address City State Female ____ **Email Address** Additional Emergency Phone Parent/Guardian Name (PLEASE PRINT) Home Phone Signature Parent/Guardian **Business Phone** Cell Phone Church Name Denomination Address Cost of Event Amount Church Campership Amount Church Enclosing Pastor's Signature Amount Parent/Guardian Enclosing Youth M ___ L ___ Balance Due from Church S ___ M ___ L ___ XL ___ XXL ___ T-shirt size: Balance Due from Parent/Guardian Adult DISCOVER 3 Digit Code Credit Card Number Card Billing Address Card Billing Zip Exp. Date Signature of Card Holder Print Name as it Appears on Card Amount to Charge DISCOUNTS ☐ Sibling – \$50 each – Sibling Camper:______ Session:_____ ☐ Early Bird - \$50 - Paid in Full (can only be applied if paid 100% prior to May 1). Cancellation one week before the beginning of camp session - Refund minus \$100.

Cancellation less than one week before beginning of camp session – No refund.

Cancellation verified by doctor certified illness – Refund minus \$100.

2022 HEALTH FORM - MUST BE COMPLETED IN FULL AND SIGNED BY PARENT/GUARDIAN

Camper's			
Last Name	First Name	Camp session	
Is this child covered by medical insurance? Yes 1	No	Family Physician or Clinic	
Is this person in general good health and able to participaties? Yes No	nte in normal activi-	Address	
ties? Yes No (If not, please submit a statement indicating limitations)		Phone In signing this application, I hereby certify that the above information is	
Problems with (check if YES).			
Hayfever Fainting Penicillin		correct and give permission for: the use of photographs including my son or daughter in publicity; for my son or daughter to be transported in camp-	
Bee Sting Convulsions Asthma		owned and camp approved vehicles to and from public transported in camp-	
Poison Ivy Sulfa Other Epilepsy (degree) Allergies		approved out-of-camp activities and; for the release of medical records in	
Lpnepsy (degree) Anergies		case of illness. I also authorize the administration of prescription medica-	
If any of the above are YES, please submit a statement of been treated and with what medication. Proper medicine		tion. Non-prescription medication will be administered following the campstanding orders.	
the camp and given to the nurse.		In case of medical emergency, I understand that every effort will be made	
All immunization will be the responsibility of the family in consultation with family physician or clinic. Give most recent date of Tetanus Booster. Then check the appropriate yes or no column to determine if camper has had		to contact parents or guardians of campers. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection,	
necessary immunizations.	1	anesthesia, or surgery for my child, as named herein.	
TETANUS BOOSTER (DATE REQUIRED) most recent date received:		(PLEASE INITIAL) I understand that this child must be covered by medical insurance	
Received: Yes No Received: Yes	es No	to be accepted into the camp program at Baptist Camp Lebanon.	
D.P.T. Series D.P.T. Booster		REQUIRED	
Polio Series Polio Booster		SIGNATURE OF PARENT/GUARDIAN	
Mumps Rubella Vac Measles Vac			
Operation or serious injury and date(s)		X	
		Telephones during camp: Day ()	
Please notify us if this child was exposed to any commun during the three weeks prior to event. Please write a note		Night () Cell ()	
any physical, emotional or psychological problem that wi and Counselor provide the best possible experience.	ll help the Nurse	Name & address of your health insurance company	
NOTES FOR NURSE			
Please list each medication and time of day that it needs t If more space is needed, please attach a separate sheet.	to be dispensed.	Policy/Group #	
		Name of Primary Insured	
		Date of Birth of Primary Insured	
		Relationship of Camper to Primary Insured	