

REGISTRATION FORM Please fill out all applicable sections and send to PO Box 70 Tyrone NY 14887

## GENERAL INFORMATION

Gender: M | F

(Name) \_\_\_\_\_ (Age) \_\_\_\_\_

(Weight) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Date of Birth) \_\_\_\_\_ (Phone) \_\_\_\_\_

(Shirt Size) \_\_\_\_\_ (Street Address) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

## ATTENDANCE

\*Mark the week(s) this camper will be attending.

Sr. High  Jr. One  Jr. High One  Jr. Two  Adventure Camp

Fine Arts Camp  Jr. High Two

## BASIC HEALTH INFORMATION

1. Has this child had any of the following?  
 Rheumatic Fever  Measles  Chicken Pox  Rubella

2. Is your child currently contagious or have they come in contact with anyone contagious?  Yes  No

3. Has your child ever had a concussion?  Yes  No  
 If yes, date(s): \_\_\_\_\_

4. Does this child have any of the following health conditions?  
 Allergy to Bee Stings  Allergy to Nuts  Asthma  
 Allergy to Peanuts  Seizures  Other \_\_\_\_\_  
 If yes, explain: \_\_\_\_\_

5. Does this camper take medication(s)?  Yes  No  
 If yes, read **MED NOTE** & fill out **MED form** to the right.

6. Is this camper bringing Over the Counter (OTC) Medicines to camp?  Yes  No  
 If yes, read **MED NOTE** & fill out **OTC form** to the right.

7. Does this camper have any life threatening conditions?  
 Yes  No

## EMERGENCY CONTACT

\_\_\_\_\_  
 (Name) \_\_\_\_\_ (Relation) \_\_\_\_\_ (Phone #) \_\_\_\_\_

\_\_\_\_\_  
 (Name) \_\_\_\_\_ (Relation) \_\_\_\_\_ (Phone #) \_\_\_\_\_

## INSURANCE INFORMATION

\*The camp insurance is an "excess plan." In the event of an emergency, providing this information will save time.

\_\_\_\_\_  
 (Carrier) \_\_\_\_\_ (Name of Insured) \_\_\_\_\_ (Policy #) \_\_\_\_\_

## IMMUNIZATION RECORD

My child is exempt from providing an immunization record. (If yes, read **EXEMPT NOTE** on this page)

My child is NOT exempt from providing an immunization record and I WILL bring this camper's immunization record with me when I drop them off at camp; I understand that this camper may not be allowed to stay if I do not submit the records at that time.

My child is NOT exempt from providing an immunization record and I will enter the dates now (**this option will allow you to move through the registration line quicker when you arrive at Lamoka**).

Varicella (chicken Pox): \_\_\_\_/\_\_\_\_/\_\_\_\_ Hep. B: \_\_\_\_/\_\_\_\_/\_\_\_\_ Polio/IPV: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 m d y

T dap: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hib: \_\_\_\_/\_\_\_\_/\_\_\_\_ MMR: \_\_\_\_/\_\_\_\_/\_\_\_\_ Tetanus: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (optional)

## PAYMENT

\*The \$50 non refundable fee **must** accompany all registrations (deducted from the total).

I will pay the full EARLY REGISTRATION amount today [\$260] [**Before June 1st**]

I will pay the full REGISTRATION (with late fee) today [\$275] [**After June 1st**]

I will pay the Registration Fee today [\$50]

\_\_\_\_\_  
 (Card #) \_\_\_\_\_ (Ex Date) \_\_\_\_\_ (CSC #) \_\_\_\_\_ (Coupon Code) \_\_\_\_\_ (Signature) \_\_\_\_\_

## PERMISSIONS & SIGNATURE

In case of an emergency I understand that every effort will be made to contact the parent or guardian while providing care for this child. I understand that emergency care will not be delayed while trying to reach the parent or guardian. In the event that I cannot be reached I give my permission to the physician selected by the camp Administrator to secure treatment or hospitalize, order injection, anesthesia, or surgery for the above named child. The health history is correct to the best of my knowledge. The camper named has my permission to participate in all camp activities unless otherwise noted to the nurse, including but not limited to, paintball, climbing wall, off campus hiking (Adventure Camp Only). Any pictures taken by camp staff can be used for future promotion of the camp. This camper has my permission to attend Lamoka Baptist Camp. I understand that drop-off is at 9am on Monday and pick up is at 9 am on Saturday.

\_\_\_\_\_  
 (Parent/Guardian) \_\_\_\_\_ (Date) \_\_\_\_\_ (Signature) \_\_\_\_\_

**MED NOTE:** All medication and over the counter medicines must be turned in upon arrival in original labeled bottle. A signed doctor's note **MUST** accompany all medications. Please use the attached (or equivalent) forms if possible. Have your doctor look over and fill out the appropriate form(s) for this camper. Our medical staff cannot administer medicines or medications that are not accompanied by these forms. If you don't have enough room print more forms at [www.lamoka.com/documents/](http://www.lamoka.com/documents/)

**EXEMPT NOTE:** By marking this child as exempt, you are declaring that this camper has either a religious exemption or you personally object to this child receiving immunizations. If this camper is exempt for religious reasons, they must bring a signed note from their pastor agreeing with the declaration.

\*For more information, please contact our office or visit [www.lamoka.com](http://www.lamoka.com)

## LAMOKA BAPTIST CAMP MED FORM

(You can use this form or the form(s) your doctor provides)

\_\_\_\_\_  
 (Name of Camper) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_

\_\_\_\_\_  
 (Medication) \_\_\_\_\_

\_\_\_\_\_  
 (Use) \_\_\_\_\_

\_\_\_\_\_  
 (Time/Frequency) \_\_\_\_\_

\_\_\_\_\_  
 (Health Care Provider's Name) \_\_\_\_\_

\_\_\_\_\_  
 (Health Care Provider's Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

\_\_\_\_\_  
 (Phone #) \_\_\_\_\_ (License #) \_\_\_\_\_



## LAMOKA BAPTIST CAMP OTC FORM

\_\_\_\_\_  
 (Name of Camper/Patient) \_\_\_\_\_ (DOB) \_\_\_\_\_

\_\_\_\_\_  
 (Weight) \_\_\_\_\_ (Health Care Provider's Name) \_\_\_\_\_

Drug Name	Provider Order	Instructions
Ibuprofen	YES NO	
Robitussin	YES NO	
Dimetapp	YES NO	
Benadryl	YES NO	
Tylenol	YES NO	

\_\_\_\_\_  
 (Health Care Provider's Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

\_\_\_\_\_  
 (Phone #) \_\_\_\_\_ (License #) \_\_\_\_\_