Camp Senior Registration Form

Name: ______________________________________ Date of birth (MM/DD/YYYY): __________________

Address: ____________________________________ City/State/Zip: ___________________________

Email: ______________________________________ Phone: ________________________________

DIETARY INFORMATION:

Please indicate any special dietary needs. All special dietary needs must be communicated prior to your arrival. ___ No Dietary Needs ___ Vegetarian ___ Vegan ___ Gluten-free ___ Dairy-free ___ Diabetic ___ Other:

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PLEASE NOTE: While we are able to accommodate a majority of dietary needs, in some cases you may want/need to bring supplemental items of your own. **Please contact Robyn Koehler** **robyn@crosswayscamps.org** / **(920) 882-0023 at least one week prior to discuss your needs/concerns.**

HEALTH & MEDICAL INFORMATION

Medications:

Name & Dose of Medication	Purpose of Medication	Frequency of Use

Allergies: This participant is allergic to ___ Food ___ Medication ___ Environment ___ Other ___ No Known Allergies

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Please indicate any additional medical information that camp staff would need to know while you are on site:

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I have reviewed the program and activities of the program and feel participation is possible:

____ without restrictions

____ with the following restrictions or adaptations: ____

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EMERGENCY CONTACTS

Name: ______________________________ Phone: __________________ Relationship: _____________

Name: ______________________________ Phone: __________________ Relationship: _____________

AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of this participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this participant. I understand the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the participant's health record from providers who treat the participant and these providers may talk with the program's staff about the participant's health status.

Signature: ____ Date: ________________________

PHOTO & MEDIA RELEASE:

I hereby give Crossways Camping Ministries consent to record, videotape and photograph the participant image and/or voice to be used for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, websites, social networking sites and other print and digital communications. I further understand that no special compensation will be provided to the participant for use of images and that I may not be informed in advance of the specific use of images.

Signature: ____ Date: ________________________

PAYMENT

Mail completed forms & $25 payment to: **Crossways Camping Ministries**
W8160 Cloverleaf Lake Rd, Clintonville, WI 54929

Contact: Robyn Koehler (920) 882-0023 or robyn@crosswayscamps.org