

PLEASE COPY THIS REGISTRATION FORM FOR ANYONE FROM YOUR CHURCH WHO WOULD LIKE TO ATTEND OUR SUMMER CAMP PROGRAM AT ALDERSGATE. WE DO NOT ACCEPT EMAIL OR FAX REGISTRATION FORMS. YOU MAY ALSO PRINT REGISTRATION FORMS ONLINE AT:

WWW.ALDERSGATECAMP.ORG

ALDERSGATE CAMP

2012 Registration & Permission Form

125 Aldersgate Camp Road, Ravenna, KY 40472

(606) 723-5078

Camper's First Name _____ Camper's Last Name _____

Camper's Preferred Name _____ Gender (Circle One) MALE FEMALE

Social Security # _____ Birth date _____ Age on 1st day of camp _____ Grade Fall '11 _____

Camper's Mailing Address: _____ City: _____ ST: _____ Zip: _____

Email: _____ Bill Church: Yes No Church will pay \$ _____

IMPORTANT: THE FOLLOWING INFO MUST BE PROVIDED IF CHURCH IS PAYING PART OF CAMPER'S FEE

Church that Camper Attends: _____ Church's Address: _____

City Church is in: _____ ST: _____ Zip: _____ Church District: _____

Minister's Name (Please Print): _____ Minister's Signature: _____

Please enroll me for: (please refer to specific camp in brochure):

1st Choice Camp Title: _____ Cost of this Camp \$ _____

Amount Enclosed \$ _____ Date that this Camp starts: _____ Date that this Camp ends: _____

2nd Choice Camp Title: _____ Cost of this Camp \$ _____

Date that 2nd Choice Camp starts: _____ Date that 2nd Choice Camp ends: _____

(You will be registered for 2nd Choice Camp if 1st choice is NOT available)

1st Choice Cabin-Mate Preference: _____ 2nd Choice Cabin-Mate Preference: _____

(Note: Cabin-Mate Preference will be considered but not guaranteed)

Camper's shirt size (for canteen inventory) Size: Child S M L Youth S M L Adult M L XL XXL

Name of Parent or Guardian _____ Home Phone: (_____) _____

Work Phone Number(s): (Mom) (_____) _____ (Dad) (_____) _____

Cell Phone Number(s): (Mom) (_____) _____ (Dad) (_____) _____

Contact person if Parent or Guardian cannot be reached: _____

Contact person's phone number(s): (_____) _____ Relationship of Contact: _____

Full payment of amount owed by camper must accompany each registration. (SEE COSTS)

Churches are requested to hold payment until bills are sent out. Checks and money orders should be made payable to: **Aldersgate Camp**, and mailed directly to Aldersgate. Returned checks will be assessed a \$25.00 fee. Registration online requires a full credit card payment. Some limited scholarships are available upon request. OPTIONAL: I am enclosing a tax exempt donation to the camp of \$ _____

NOTE: MEDICAL INFORMATION ON REVERSE SIDE MUST BE COMPLETE.

2012 MEDICAL INFORMATION

Name of Doctor (Please Print) _____ Doctor's Phone # (_____) _____

Medical Insurance Co. _____ Policy No. _____ Name of Card holder _____

Is camper on any medication? No _____ Yes _____ If yes, please list medicines and purpose of each: _____

Please provide a written summary of the following: Past medical treatment, dietary restrictions, immunizations.

Please provide a description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. _____

Date of last Tetanus Shot: _____ Are there special needs we should be aware of? Yes _____ No _____

If yes, please list: _____

Please Circle Allergies Camper Has: None Bee Sting Penicillin Sulfa Drug

Other Allergies _____

Detail of above reactions or other medical info: _____

IMPORTANT: Recommendations and restrictions from camp activities (diet, medicine, swimming, etc.) _____

DO NOT release my child to: _____

I give permission and consent for my child to participate in any and all camp activities including, without limitations, swimming pool, creek, hiking, horseback riding, caving, games, ropes course, etc., and off-site activities, including transportation to and from, (except as noted above). I certify that my child is in good physical condition for all camp activities. I understand that the nature of outdoor camping ministries includes some risk of injury or death. I realize that campers can become ill and need medical attention. I hereby give permission to the camp Health Care Provider to give over the counter medication (such as Advil, etc.) to my child as proper treatment as deemed necessary for minor ailments. In case of emergency, I hereby give permission to the physician, nurse, hospital, etc. selected by the Camp Director (or his representative) to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named above. In case of illness or accident, I give permission for the release of medical records for medical and insurance purposes. I hereby release Aldersgate from responsibility for the injury of my child. I agree to submit my insurance claims to my insurance carrier first and will only use Aldersgate's insurance plan as a secondary insurance. I give permission for the use of photographs or video including my child in camp publicity and for the distribution of my child's mailing address to campmates. This completed form may be copied for transportation records.

Camper's Signature (ages 10 & older) _____ **Date:** _____

Parent/Guardian's Signature _____ **Date:** _____

How many years has Camper attended Aldersgate? _____ How did you hear about Aldersgate? _____

Mail completed form to: Aldersgate Camp, Attention: Registrar, 125 Aldersgate Camp Rd, Ravenna, KY 40472

Camps are filled on a "first come / first serve" basis. If information on this form is incomplete, form will be returned to Camper's mailing address and Camper will not be registered until completed form is submitted.