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June 19-23, 2017

FOR OFFICE USE ONLY

- Information
- Release Signature

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PROGRAM PERSONALITY REGISTRATION FORM

Please complete each page of this form and send it to the camp office.

PERSONAL INFORMATION

Name (first) _____ (last) _____
 Birth Date (mm/dd/yyyy) _____ Age _____ Gender _____
 Physical (NOT Mailing) Address _____
 City _____ State _____ Zip Code _____
 Mailing Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____
 E-Mail _____ T-Shirt Size: **Adult** S M L XL 2XL

Spouse/Emergency Contact

Name (first) _____ (last) _____ Relationship _____
 Physical Address (if not sponsor's address) _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____
 Work Phone _____ E-Mail _____
 Place of Employment _____ Employer Address _____

Additional Emergency Contact

Name (first) _____ (last) _____ Relationship _____
 Physical Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____

HEALTH INFORMATION

Health History:

Please list all communicable diseases that you have had contact with in the last two weeks. (common cold, strep throat, pink eye, etc.) _____

Check if you have or had the following:

- | | | | | |
|---|---------------------------------------|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent Ear Infections | | |
- Health Concerns over Altitudes of 8000'
 Surgeries & Dates _____
 Dietary Restrictions _____
 Other _____

Date of last tetanus shot _____

Medications:

All Medications, prescribed, over-the-counter, and vitamins must be kept in a locked and secure place. You should be lodging in a private room inaccessible to campers, and your room should remain locked.

Allergies: Check if you are allergic to: Insects Foods Drugs

Please describe _____

Family Physician _____ Phone (_____) _____

Physician's Address _____

Insurance Provider _____ Phone (_____) _____

Policy Number _____ Group Number _____

RELEASE AND WAIVER OF CLAIMS

In the event that I should need emergency medical care or attention, Hesperus Baptist Camp (HBC) or any one of its agents or employees is hereby authorized to provide such emergency medical care, including without limitation, medical, dental, surgical care or hospitalization, to me as is recommended or suggested by a health care professional.

If such emergency care is provided, I understand that my health insurance information will be given to the health care professional and that any expenses not covered by my insurance shall be my responsibility. I understand that HBC will not be obligated to pay either the health care professional or me for any medical expenses incurred.

There are instances when third party contractors are used to operate and supervise various events and activities (such as whitewater rafting). In those instances where third party contractors are used, I agree to hold harmless the third party contractor and HBC for the action of these third party contractors with respect to injury, disability, death, or loss or damage to person or property. I further agree that HBC is also not liable for the actions or activities of participants or sponsors participating in events or activities operated by third party contractors.

I understand that the risk of injury from any recreational activity (including whitewater rafting and zip lines) is significant, including, but not limited to, the potential for permanent paralysis and death. While particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist. I knowingly and freely assume all risks, both known and unknown, even if arising from negligence, and assume full responsibility for my participation and observing of such recreational activity.

Furthermore, in consideration of being allowed to attend HBC, I hereby waive any and all causes of action, rights, claims or suits which I may have against HBC, its agents or employees as a result of injury to me, including, but not limited to: (1) injuries arising from participation in or observation of recreational activities at HBC, and (2) injuries arising from the decision of HBC or its agents or employees to consent to the provision of emergency medical care to me.

I give authority and permission to HBC, its employees or its agents to inspect my belongings while at HBC.

Signature _____ Date _____

Name (Printed) _____