

First Bible Baptist Church - Junior Camp Registration

Must be returned by June 15th. Camp Fees: \$130 (8-12 yr. old) per person

Please be sure to fill out ALL of this form and enclose a deposit check for the amount of \$20 (or the full amount of \$130) made out to: "First Bible Baptist Church" and send it to: FBBC / Jr. Camp • P.O. Box 644 – 12 Granger Lane • Plainville, CT 06062.

Camper's Name: _____ Date of Birth: ____ / ____ / _____ Age: _____

Full Address: _____

Home Phone: _____ Work Phone: _____

Parent's Names: _____ Church or Pastor's Name: _____

T-Shirt – Child Size: Small (6-8) Medium (10-12) Large (14-16) Xlarge (18-20)

T-Shirt – Adult Size: Small (34-36) Medium (38-40) Large (42-44) Xlarge (46-48)

Medical Information and Authorization for Medical Emergency

• ALL medication **MUST** be in the child's name. • PLEASE DO NOT bring over the counter medications. We will supply if needed!

Allergic Reactions: _____

Type of Reaction: _____ Treatment Given: _____

Special Needs _____

Date of last Tetanus shot: ____ / ____ / ____ (Tetanus shots should be up-to-date). DTAP has to be less than 10 yr. old.

Medical Authorization: In case of Medical emergency, I hereby give my permission to the staff member in charge to: Hospitalize, and/or secure the services of a licensed physician, surgeon, or anesthetist in providing the necessary care for my child as named on this application. I certify that my child is in good physical condition, and is able to participate in the entire camping program except for activities listed as "restricted".

Signature of Parent or Legal Guardian: _____ Date: _____

Authorization for the Administration of Medicine by Camp Personnel (to be filled out by Doctor)

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, Frequency: _____

Relevant Side effects: None Expected Specify: _____

Allergies: Yes No (specify) _____

Medications shall be administered from: June 23, 2008 to June _____, 2008

Prescriber' Name/Title: _____

Telephone: _____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

Parent/Guardian Authorization: I hereby request that the above ordered medication be administered by camp personnel. I understand that I must supply the camp with no more than a 5 days supply of medication. I understand that this medication will be destroyed if not picked up within one week following the termination of the order or the last day of camp, whichever comes first..

Signature of Parent or Legal Guardian: _____ Date: _____