

Children's Camp #1 July 1-6 Ages 10-12

Children's Camp #2 July 8-13 Ages 7-9

Please PRINT Clearly

Name: _____

Date of Birth: _____ Age: _____

Male Female

Address: _____

City: _____ Prov: _____

Postal Code: _____

Name of Parent/Guardian: _____

Phone # (daytime): _____

Phone # (evening): _____

E-mail: _____

Please send additional info by: Mail E-mail

Name of desired roommate: _____

I would like to order a camp T-shirt:

Small Medium Large X-Large

(Sizes of T-shirts can not be guaranteed for registrations received after June . T-shirts **may** be available for sale at time of registration.)

Enclosed is:

Early Bird Registration (Prior to June 1st)\$250.00

Registration Fee (After June 1st).....\$275.00

T-Shirt\$15.00

Memory Stick of Camp Photos\$12.00

Total\$ _____

The cost of registration includes \$7.50 for Tuck. Please do not send additional money or candy.

To request E-Transfers please email: zionhillkidscamp@gmail.com

Important Information

Camp concludes the Friday of each week at 7:00pm. My child will be picked up by: _____

Or by: _____

Signature of Parent/Guardian: _____

Date: _____

Please Note: Parents/Guardians must sign their child out at the end of camp before leaving the grounds.

Camper Medical Form

Zion Hill Children's Camp 2018

Please Print

Camper Info

Last Name: _____ Female

First Name: _____ Male

Home Address: _____

City: _____ Prov: _____

Postal Code: _____ Date of Birth: _____

Age as of Sept. 1st, 2018: _____

Health Card # _____

Contact Info

Primary Contact Name: _____

Relationship to Camper: _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

In Case of Emergency Contact

Name: _____

Relationship to Camper: _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Name of Family Physician: _____

Doctor's Phone # _____

First Aid Info

I give permission for the medications outlined on the registration form to be administered to my child by the First Aid Attendant of Zion Hill Youth Camp. I consent for First Aid to be administered to my son/daughter as necessary. I also agree that the following medications and lotions/creams may be applied as necessary.

Please indicate by circling YES or NO.

YES NO Benadryl for allergic reactions.

YES NO Tylenol for fever or headache.

YES NO Advil for fever or headache.

YES NO Gravol for nausea/vomiting.

YES NO Calamine Lotion
(insect bites/minor skin irritations)

YES NO Polysporin to prevent infection/speed the healing of minor cuts and scrapes.

Signature of Parent/Guardian: _____

Date: _____

Allergies

None

Drug Allergies:

Penicillin Sulfa Anesthetic Acetaminophen

Codeine

Other Describe: _____

Environmental Allergies:

Bee Stings Pollen Hayfever Animal Dander-

Dust/Mold Latex

Other Describe: _____

Food Allergies:

Lactose Intolerant Peanuts Nuts

Food Dye Gluten

Other Describe: _____

Describe reaction to allergies checked above:

Anaphylactic reaction to allergies: Yes No

Epi Pen: Yes No

Child Knowledge of Use of Epi Pen: Yes No

Epi Pen kept on child's person: Yes No

Ventolin Inhaler: Yes No

Child knowledge of use of inhaler: Yes No

Inhaler kept on child's person: Yes No

Special Instructions (Please Attach An Additional Page)

Please outline any special instructions concerning care, medication, diet, allergies, custody, etc.

