

# JUNIOR HIGH & HIGH SCHOOL CAMP COUNSELOR CARD

If under 18 years of age, please have the reverse side filled out and signed.

CAMP: \_\_\_\_\_ DATE OF CAMP: \_\_\_\_\_

NAME: \_\_\_\_\_ M/F \_\_\_\_\_  
Last First

ADDRESS: \_\_\_\_\_ Apt. # \_\_\_\_\_  
Street

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Cell Phone or Pager

ROOMMATE REQUESTS: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**I do give my consent to have my son/daughter participate with the students from Calvary Chapel Costa Mesa in any and all activities.**

### **OTHER EMERGENCY CONTACTS:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy #: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

1. To your knowledge, has your child been exposed to any communicable diseases within the past 21 days? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

2. Do you know of any health factor(s) that make it advisable for your child to follow a limited program of physical activity? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

School Attending: \_\_\_\_\_ Church Attending: \_\_\_\_\_

Check Amount	Check No.	Cash Amount	Date	By
\$ _____	_____	\$ _____	_____	_____
\$ _____	_____	\$ _____	_____	_____

**NOTE: BALANCE IS PAYABLE 2 WEEKS PRIOR TO CAMP TO CONFIRM SPACE**

**HEALTH HISTORY:** To protect your child from possible embarrassment, but not to exclude him/her from the Program, please list any health concerns that we should be aware of. Also include any known allergies to drugs/and or insect stings.

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

Frequent Ear Infections \_\_\_ Heart Defect/Disease \_\_\_ Convulsions \_\_\_ Diabetes \_\_\_ Bleeding/Clotting Disorder \_\_\_ Sleep walking \_\_\_  
Night-Time Incontinence \_\_\_ Operations/Serious Injuries \_\_\_ Chicken Pox \_\_\_ Measles \_\_\_ German Measles \_\_\_ Mumps \_\_\_

Date of Child's last tetanus shot: \_\_\_\_\_

Name and phone number of your Child's regular physician: Dr. \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

**PLEASE LIST ANY MEDICATION THAT YOUR CHILD WILL NEED TO HAVE WHILE AT CAMP:**

MEDICATION:	DOSAGE:	WHEN TAKEN:
_____	_____	_____
_____	_____	_____

\*\*In the event of a minor illness or injury (such as cold, headache, scrapes, sprains, abrasions, and/or small cuts), I do authorize the Youth Pastor, R.N. or EMT to give my child common remedies such as Tylenol, cough medicine, etc., in dosages appropriate for his/her age, and to clean and bandage or wrap wounds as necessary.

**IMPORTANT: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN**

The health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and/or my physician. I hereby give permission to the physician selected by the Youth Pastor (or his/her representative) to order X-rays, routine tests, and treatment for the health of my child and to order injections and/or anesthesia and/or surgery for my child named above. This authorization is given pursuant to Section 25.8 of the Civil Code of California. This authorization shall remain effective through the extent of the scheduled program with Calvary Chapel of Costa Mesa unless sooner revoked in writing and delivered to said agent. I further agree that Calvary Chapel of Costa Mesa, its Board of Directors, officers, and staff are hereby relieved of all liability in the event of accident or injury to said Minor.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work/Emergency Phone: ( ) \_\_\_\_\_