

# Word of Life Camp 2010 Application

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Camper's name: \_\_\_\_\_ M/F

Camper's DOB : \_\_\_\_\_ MM/DD/YYYY

Parent/Guardian name: \_\_\_\_\_

Parent/Guardian phone numbers:

home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Home church: \_\_\_\_\_

Pastor's name: \_\_\_\_\_

Church/Pastor phone number: \_\_\_\_\_

Does Camper have any special medical or behavioral problems or allergies? Y/N If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Camper allergic to any medications, foods, etc.? Y/N If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does Camper take any medication? Y/N If yes, please explain and detail dosage schedule: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read the above application and verify that the information presented above is current and accurate.

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

Date: \_\_\_\_\_

# Word of Life Camp 2010 General Waiver

I hereby certify that my son/daughter, \_\_\_\_\_, has permission to attend Word of Life Camp 2010, from Friday, July 9-Monday, July 12, 2010. I agree and so hereby release and discharge any counselor or other person engaged in the activity hereinabove described from all claims, present and future, known and unknown, in any manner arising out of the above described activity. I further understand and agree that this waiver releases any counselor to my son/daughter from responsibility resulting from any and all personal injury or illness that may be suffered by my child, and further, I agree to hold them blameless from any loss of property by my son/daughter that may occur during the above described activity. It is understood that no child will be allowed to participate in this activity if this form is not completed and signed by his/her parent or guardian.

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

Date: \_\_\_\_\_

In case of emergency, I give permission to the Word of Life Camp administrators, counselors or administrators to obtain medical treatment for my child in my absence.

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

Date: \_\_\_\_\_

# Word of Life Camp 2010

## Emergency Medical Treatment Procedure and Consent for Treatment Form

It is the general policy of Word of Life Fellowship to transport to the local emergency room any child who is injured while in our care and requires emergency treatment. We will follow this general policy if the person in charge judges that a delay in securing treatment would not be in the best interest of the child. As soon as possible, parent(s)/guardian(s) will be notified that said child is being taken for medical treatment, should the need arise. Due to hospital regulations for treatment, we request that you sign a Parental Responsibility Designation Form for each child under the age of 18. **THIS MUST BE OBTAINED BEFORE YOUR CHILD CAN PARTICIPATE IN THIS ACTIVITY!** These forms will be retained in the possession of responsible parties at all times.

### EMERGENCY INFORMATION

We will need to take certain information with us when we attend activities. We ask that you help us by filling out this form legibly and turn it into the appropriate person.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

In case of emergency and the Parent/Guardian cannot be reached, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Special Information and Health History:

Any known allergies  
How to treat them

Have you had:	Yes	No	Are you subject to:	Yes	No
An attack of appendicitis			Sinus trouble		
Asthma or hay fever			Fainting spells		
Hernia			Ear trouble		
Rheumatic Fever			Poison Ivy, oak, etc.		
Diabetes			Reaction to penicillin		
Do you take insulin?			Nervous or upset east		
Poliomyelitis			Allergy to aspirin		
Heart Trouble			Are you under medical care requiring medication?		
Scarlet Fever			Is your activity restricted due to medical reasons?		
Significant disease, injury or operation					

Date of last Tetanus shot \_\_\_\_\_

**IF THE ANSWER IS “YES” TO ANY OF THE PREVIOUS QUESTIONS, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER AND ATTACH IT.**

**Physician Information**

Child’s Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Insurance Information**

Name of Policy Holder \_\_\_\_\_  
SSN of Policy Number Holder \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_  
Phone Number of Insurance Company \_\_\_\_\_  
Child’s Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**PARENTAL/GUARDIAN CONSENT FOR MEDICAL TREATMENT FORM**

I, (we), the undersigned, parent(s) of \_\_\_\_\_  
From the dates of \_\_\_\_\_ to \_\_\_\_\_ do hereby grant  
permission for medical treatment during this time period. The below named person(s) may grant medical treatment  
during the time period listed above.

\_\_\_\_\_  
Name(s) of responsible leader(s)

Parent/Guardian Signature \_\_\_\_\_  
Name Printed \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_  
Name Printed \_\_\_\_\_ Date \_\_\_\_\_

You may request a copy of this form for your records. If you have any questions, please contact the church office at (304) 269-6492.