Battlefield Baptist Church Permission Slip
CAMP 180 / July 9-13, 2018
Camp Heritage, Chesterfield, VA

Child's Name _____ Age____ Gender ____ Grade (in Fall)____

Address _____

Parent/Guardian _____ Phone #_____

Email _____ Cell #_____

Emergency Contact & Phone #_____

T-Shirt size (circle 1): YS YM YL AS AM AL AXL A2X A3X

I understand that images of my child may appear on the Heritage Baptist Church website, live broadcasts during camp week, and other camp promotional sites.

Parents Please initial: _____

COST: $175 per camper

(A $25 non-refundable fee per child is required at the time of registration.)

(Total Price includes a $25 non-refundable registration fee, transportation, and T-shirt)

***All Permission Slips and Camp Fees are due no later than Sunday, June 17th.**

NOTE: *All registrations are on a FIRST COME, FIRST SERVED BASIS. Because of its size, this camp fills up quickly… PLEASE do not delay – REGISTER TODAY!*

I, _____, give permission for my child _____, to accompany Battlefield Baptist Church to **Camp Heritage {Camp 180}** in **Chesterfield, Virginia,** from **July 9-13, 2018,** and to participate in all camp activities. I waive all claims against Battlefield Baptist Church and/or leadership, including camp volunteers, of any injuries that may be sustained by our said minor child and agree to indemnify and hold the church and workers free and blameless from any liability, costs, and damages therefore. I hereby consent to and grant the leadership of Battlefield Baptist Church full rights and authority to act for me in any manner pertaining to the care and control of the said minor child named above during this week of camp (July 9-13, 2018). If for any reason this child needs to leave camp early, I accept responsibility to arrange and pay for the child's transportation home. Additionally, I grant Battlefield Baptist Church leaders my consent to obtain medical assistance that may be required for my said minor child during this week as deemed necessary. I agree to accept financial responsibility for the costs related to this emergency medical treatment.

Parent's Signature _____ Date_____

TURN OVER TO COMPLETE BOTH SIDES

Parent's Printed Name: _____

Medical Insurance Company: _____

Medical Insurance ID #: _____

List allergies, if any: _____

List medications, if any: _____

Year of last tetanus shot: _____

Does the child have any special problems, conditions or restrictions? Yes____ No____

If yes, please explain: _____

_____

_____

Please list any special instructions: _____

_____

_____

_____

_____

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TURN OVER TO COMPLETE BOTH SIDES