FOURSQUARE CAMP

NORTH SOUND DISTRICT

FOURSQUARE CAMP

HIGH SCHOOL | AUGUST 5–10
MIDDLE SCHOOL | AUGUST 12–16

WWW.FOURSQUARECAMP.COM

GENERAL CAMP INFORMATION

HIGH SCHOOL: AUGUST 5–10 MIDDLE SCHOOL: AUGUST 12–16
SILVER LAKE BIBLE CAMP | MEDICAL LAKE, WA

CAMP COST:

PLEASE CONTACT YOUR YOUTH PASTOR OR YOUR CHURCH CAMP COORDINATOR
FOR CAMP FEES AND TRANSPORTATION DETAILS

*No refunds after July 22, 2019

PLEASE REMEMBER TO SEND YOUR STUDENT WITH A SACK LUNCH OR MONEY FOR LUNCH ON THE WAY TO AND FROM CAMP.

PACKING LIST:

ONE SUITCASE | BIBLE | JOURNAL | PEN & PENCIL
SLEEPING BAG | PILLOW | MODEST CLOTHING | CLOTHING FOR CAMP COLOR WARS | PAJAMAS
MODEST-ONE PIECE SWIMSUIT | TOWEL
SHAMPOO & CONDITIONER | TOOTHBRUSH & TOOTHPASTE | DEODORANT
FLASHLIGHT | SUNSCREEN | $$ FOR CAFE | CAMERA (AT YOUR OWN RISK)

SEND MAIL:

ATTN: STUDENT'S NAME
SILVER LAKE CAMP
10919 LAKEHURST DRIVE
MEDICAL LAKE, WA 99022

IF YOU ARE PLANNING TO SEND MAIL OR PACKAGES, PLEASE DO SO EARLY IN THE WEEK

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REGISTRATION DEADLINE: JUNE 23, 2019

STUDENT NAME

GENDER ☐ M ☐ F

BIRTH DATE ___ / ___ / ___

AGE

GRADE GOING INTO

STUDENT CELL

SHIRT SIZE (IN MENS) ☐ XS ☐ S ☐ M ☐ L ☐ XL

ADDRESS

CITY

STATE

ZIP

PARENT/GUARDIAN NAME

GUARDIAN PHONE ( )

PARENT/GUARDIAN EMAIL

DIETARY RESTRICTIONS

SEVERE ALLERGIES

TAKING MEDICATION? ☐ YES ☐ NO

ROOMMATE REQUEST

EMERGENCY CONTACT

PHONE ( )

RELATIONSHIP

HEALTH INSURANCE CO.: *(CAMP INSURANCE IS SECONDARY TO PERSONAL HEALTH INSURANCE)*

GROUP #

POLICY #

FOURSQUARE CAMP

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ACTIVITY PERMISSION, RELEASE, AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of _____ (The child), give permission for my child to participate in the activity described on the reverse and release, from all liability and indemnify the International Church of the Foursquare Gospel : Northwest District, and its directors, officers, council, agents, representatives, volunteers, and employees ("NWD") from any and all liability, claims, judgments, cost or expense, including attorney fees, arising out of any damage, injury or illness incurred or caused by my child while participating in or traveling to or from the activity, or otherwise in camp custody. I understand the risks in these activities, including the possibility of unforeseen hazards, serious injury or death. I certify my child is able to participate in the activity.

2. I agree to instruct my child to cooperate with the camp and it's representatives in charge of the activity and understand my child may be prohibited from participating and or sent home for any failure to follow the rules established by the NWD.

3. I appoint district representatives who are acting as leaders, or designated by such leaders as my attorney in fact to act for me in my name and my behalf, in any way that I could act if I were personally present with respect to the following matters if any injury, illness, or medical emergency occurs during the activity, related travel, or while my child is in camp custody.

    A. To give any and all consent and authorization to any physician, dentist, hospital or other persons or institutions pertaining to any emergency actions as our medical attorney in fact shall deem necessary or appropriate for the best interest of the child.

    B. I understand the NWD will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

4. I agree that the NWD may use my child's and or my own name, voice, portrait, photograph or image for promotional website, office or any other district related purpose. These may be used in any broadcast, telecast, digital or print medium, including video images, photographs, pictures, or renderings, audio recordings, or there likenesses, in combination or alone.

5. My child is to be EXCLUDED from the following activities_____ and/or from release to the following persons_____

I will notify the church immediately of any change in the information presented and agree it is valid until revoked in writing by me. I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

_____ _____

Signature of Parent or Guardian Date

FOURSQUARE CAMP

STUDENT / LEADER MEDICATION FORM

ALL students/leaders must complete this form

(confidential for medical provider/emergency use only)

LAST NAME:_____ **FIRST NAME:**_____

AGE:_____ DATE OF BIRTH:_____

CHURCH: _____

PLEASE DO THE FOLLOWING:

1. Write the **NAME** of the medication or supplement being taken in the **MEDICATION/SUPPLEMENT** column.
2. Write how **OFTEN** it is taken daily in the **DIRECTIONS** column.
3. **LEAVE** daily gray columns **BLANK**; this is for the nursing staff to use each day at camp.
4. **PLEASE DO NOT** send any loose medications or vitamins. **ALL PRESCRIPTION & NON-PRESCRIPTION** medications **MUST** be in original containers. All prescriptions must have patient name and dosage amount on containers.

Medication / Supplement	Directions	Mon	Tue	Wed	Thurs	Fri	Sat

Recent illnesses / injuries:_____

History of trouble with: (please circle) Migraines Seizures Asthma Heart Issues Diabetes Other

Please explain any circled:_____

Allergies: Tree Nuts Peanuts Gluten Dairy Hay Fever Bee Stings Other/Meds:_____

Symptoms of allergic reaction:_____

Treatment:_____

If anaphylactic, do you give EPI first or Benadryl?_____

Head injuries: Concussions 1 2 3 4 When_____ Where_____

My child may receive over the counter medicine (i.e. Benadryl, Tylenol, Ibuprofen, Cough Drops, etc.) from the camp nurse. Yes No Exceptions:_____

Emergency Contact:_____ **Phone:**_____

Relationship to you:_____ **Alternate Phone:**_____

Home Address:_____

PARENT SIGNATURE: ***X***_____ **DATE** _____