Kamper Name _____ First _____ Last _____

Church _____ Cabin _____

Registration Form 2018

Kids Mission Adventure Kamp

KMAK I June 11-14, KMAK II June 18-21. KMAK III July 23-26

Youth Small Youth Large

Adult T-Shirt sizes (circle one **S M L XL XXL XXXL**

Name of person attending camp: _____

School Grade Completed_____ Sex (circle one) **M F** Age_____ Birth date_____

Sponsoring Church: _____

Parent or Guardian (of minor) _____Home Phone _____

Address_____ City_____ St_____ Zip_____

In case of emergency notify: _____ Relationship_____

Emergency phone numbers: Day_____ Night_____ Cell _____

Physician's Name_____ (Imperative if your child has allergies.) Phone_____

List any allergies to medications or any known allergies_____

_____

Date of last tetanus immunization_____ List medications presently being taken:

_____

_____

Medical Insurance Company_____ Insurance Policy #_____

(This above information is needed in case your child or the sponsor has to taken to the hospital and the parent/guardian cannot be reached.)_____ Date_____

Signature of Parent /Guardian/Sponsor

AUTHORIZATION FOR EMERGENCY CARE TO A MINOR

I/we the undersigned, parent(s) or legal guardian of the minor (name) _____ (birthday)_____, do hereby authorize any X-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of:

_____

(Name of adult sponsor who is temporary custodian of minor)

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

Date_____ Parent /Legal Guardian_____

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE

I hereby authorize the hospital to release the following information contained in its hospital records to the representative of the Tulsa Metro Baptist Association concerning Diagnosis, prognosis for

_____ Date of birth _____

Name of Camper/Sponsor

This information will be used for insurance billing. _____ Date _____

Signature of Parent or Guardian/Sponsor

Please **make sure you have one (1)** ***ORIGINAL*** **and one (1) copy of each registration form.**

ORIGINAL **(1) copy to registration at Kamp. CHURCH keeps one (1) copy**

Revised 2018