

2010 SUMMER YOUTH CAMP REGISTRATION

One camper per form; download additional forms at www.campgilead.org

OFFICE USE ONLY			
CHECK #	AMOUNT RECEIVED	DATE RECEIVED	CABIN

YOUTH CAMPER INFORMATION - 2010

Last Name _____ First Name _____
 Mailing Address or P.O. Box _____ (apt. #) _____
 City _____ State _____ Zip _____
 Home Phone number _____ Email address _____
 Home Church _____
 Parent's or Guardian's First and Last Name _____
 Parent work phone _____ Parent cell phone/pager _____
 Emergency Contact: Name _____
 Contact Phone # _____
 Relationship to camper _____
 Age _____ Sex _____ Grade Fall 2010 _____ First Time Camper – Yes / No (circle one)
 If yes, invited by: (must be returning camper) _____
 How did you hear about Camp Gilead? _____
 Roommate Request (one only please) _____
 T-shirt size (circle one):
 Youth M Youth L Youth XL Adult S Adult M Adult L Adult XL Adult 2X

2010 CAMP DATES - Please check your week of camp (grade in the Fall 2010)

✓	CAMP	DATES	GRADES	COST
	Day Camp #1	July 26 - 30	K-3	\$230
	Day Camp #2	August 2 - 6	K-3	\$230
	Day Camp #3	August 9 - 13	K-3	\$230
	Day Camp #4	August 16 - 20	K-3	\$230
	Resident Junior Camp #1	August 2 - 7	5-7	\$260
	Resident Junior Camp #2	August 9 - 14	3-5	\$260
	Resident Junior Camp #3	August 16 - 21	4-6	\$260
	Resident Teen Camp #1	July 12 - 17	7-9	\$270
	Resident Teen Camp #2	July 19 - 24	8-12	\$270
	Resident Teen Camp #3	July 26 - 31	6-8	\$270

PAYMENT OPTIONS

CREDIT CARD INFORMATION <small>(Not on file from previous use.)</small>		\$100 minimum deposit required (nonrefundable, nontransferable and included in cost)	\$
Master Card <input type="checkbox"/>	VISA <input type="checkbox"/>		
CREDIT CARD # _____	EXP. DATE _____	Paid in full by March 1st Subtract \$20 from cost	\$
NAME ON CARD _____		Paid in full by May 1st Subtract \$10 from cost	\$
BILLING ADDRESS _____	CITY _____	Deposit to Pop's Inn Spending money	\$
STATE _____	ZIP _____	Donation to the Memorial Scholarship Fund at Camp Gilead	\$
STREET ADDRESS _____	CITY _____	Donation to the Capital Campaign	\$
STATE _____	ZIP _____	TOTAL PAYMENT	\$

Partial Scholarships Available: Please contact saramoyer@campgilead.org

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MEDICAL HISTORY

Name _____
 Height _____ Weight _____ Date of Birth _____
 Family Doctor or Pediatrician _____
 Hospital or Clinic _____ Phone number of clinic _____
 Date of last tetanus immunization _____
 Allergies _____
 Known health restrictions _____
 Activity Restrictions _____
 Medications taken regularly _____
 Permission to administer over the counter medications: (circle one) Yes No
 (i.e. Tylenol, Sudafed etc.)
 Insurance Co. and Policy # _____
 Subscriber Name _____
 Relation to camper _____

CONSENT

Parent Authorization
 This health form is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted by me and to be photographed and videoed for Camp Gilead promotional use. In case of medical emergency, I hereby give permission to the physician or health care professional selected by the camp director to administer or secure proper emergency treatment and hospitalize, as he/she deems necessary. I understand that Camp Gilead only carries secondary insurance for campers, and that I will take primary responsibility for any charges incurred in the event that the camper above should need any medical attention at any clinic, facility or hospital. In the event that a camper is not covered by an insurance policy, Camp Gilead will provide primary coverage.

Parent Signature and Date: _____

Parents please send all medications in the original container with dispensing instructions. Notify Camp Gilead if child is exposed to any communicable illness or pest during the three weeks prior to their camp.

Camper Contract
 As the camper, I agree to abide by all camp regulations and policies and to uphold its objectives.

Camper Signature and Date: _____

Please mail completed registration form to:
 30919 NE Carnation Farm Rd., Carnation, WA. 98014