

REGISTRATION 2019

Complete and Mail to:
Camp Shetek P.O. Box 141
Slayton, MN 56172



Camper Information

Name: _____

Gender: _____

Birth date: _____

Grade in Jan of 2019: _____

Address: _____

City: _____

State: _____ Zip: _____

Parent/Guardian: _____

Phone#: _____

Church Sponsor (if known): _____

Choose Your Camp

- ☐ **Camp #1** - July 1-6 / Grade Completed 10-12
- ☐ **Camp #2** - July 8-13 / Grade Completed 8-9
- ☐ **Camp #3** - July 15-20 / Grade Completed 6-7
- ☐ **Camp #4** - July 22-26 / Grade Completed 4-5
- ☐ **Camp #5** - Jul 29- Aug 2 / Grade Completed 2-3

* *Campers may not attend camps designated for age groups other than their own.*

CHOOSE YOUR PAYMENT

- A. ☐ **\$325** - Actual cost to attend camp
- B. ☐ **\$300** - This discounted option is available if your completed registration and full payment are both received by May 15.

\$

Total Amount Enclosed

Signature

- * I affirm there is no need of a doctor's examination prior to camp based on good health history, or that such an examination has been obtained in the last 90 days and is included with this registration.
- * I affirm that I have read the brochure and support the policies of the camp. I understand that Shetek Baptist Camp reserves the right to dismiss any child (without refund) whose action, behavior or attitude, in their judgment, is contrary to the best interests of the camp.
- * I give permission to camp health care personnel to provide routine health care and to administer medications brought to camp or over the counter medication as they deem necessary.
- * I understand I will be contacted if my child needs medical treatment at a clinic or hospital. In the event I cannot be reached in an emergency, I give permission to the camp to arrange necessary transportation and the physician selected by the camp staff to secure and administer treatment.
- * I agree that any photographs/video taken at camp that include the registered camper, may be used for camp publicity.
- * I understand that early departures must be pre-approved by completing the early departure form from the camp website.
- * **I understand that this registration will only be processed if both pages of this form (pages A & B) are filled out completely with full payment enclosed.**



Parent/Guardian Signature

Date

OVER

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Health & Insurance

Emergency Contact Phone #1: _____ Name _____ ☐ Dad ☐ Mom ☐ Other
Emergency Contact Phone #2: _____ Name _____ ☐ Dad ☐ Mom ☐ Other
Do you carry family medical/hospital insurance ☐ Yes ☐ No Insurance Company: _____
Insurance Policy #: _____ Name of Insured: _____

Medications

1. Bring any needed prescription medications with you to camp. **All** medications must be turned in to the First Aid Station.
2. All medication (including over the counter) must be in the original container with original label.
3. Place all medications in a zip style bag. Write the camper's name and parent's phone number on the outside of the bag with a permanent marker. Write clear instructions on a slip of paper and place it inside the bag.

Immunizations & Conditions

4. ☐ Yes ☐ No Is your child current on all immunizations needed for school? - List exceptions: _____
5. Conditions: ☐ Anxiety ☐ Epilepsy ☐ Asthma ☐ Sleep Walking ☐ ADD ☐ ADHD ☐ Allergies ☐ Drug Reactions ☐ Other
Clarify: _____
6. During the school year, does your child require or receive any special services such as a management aide?
☐ Yes ☐ No Explain: _____
7. *Are there any current conditions (injury, surgery, illness) that may require special attention, or restrictions while at camp?
☐ Yes ☐ No Explain: _____
8. *Has the camper received professional treatment to address mental or emotional health in the past 2 years?
☐ Yes ☐ No Explain: _____
9. *Has the camper been exposed to a communicable disease in the past 6 months?
☐ Yes ☐ No Explain: _____

If more space is needed to clarify your answers, write a separate document and attach it to this form

**Section below is required if answering yes to any questions 7-9 above. Must be completed by your attending health professional.*

Physician's Statement

Date: _____

- A. The person named on this health history is/has been under my care for the following: _____

- B. Is this person able to participate in an active camp program? Explain: _____

- C. Detail treatments to be continued while at camp: _____

- D. If camper has been exposed to a contagious disease, is period of contagion over? _____

Signature & Phone # of Licensed Medical Personnel: _____

OVER