HAWAII PACIFIC BAPTIST CONVENTION

Children's Mission Adventure Camp 2016 (GA & RA) on March 23-25, 2017

PARTICIPANT INFORMATION AND MEDICAL RELEASE FORM

Participant, please complete form, or have parent or guardian sign form, and then turn it in to your coordinator.

PARTICIPANT'S NAME: _____ (M / F); Leader: _____

ADDRESS: _____ TELEPHONE NO: _____

CITY, STATE, ZIP CODE: _____ Email: _____

CHILD's INFO:

T-Shirt size (circle one): Youth S Youth M Youth L Youth XL

AGE: _____ DATE OF BIRTH: _____ CURRENT SCHOOL GRADE: _____

CHURCH CHILD ATTENDS: _____ CHRISTIAN? _____ BAPTIZED? _____

Father's Name: _____ Mother's Name: _____

ADULT INFO:
T-shirt Size (circle one): Adult S Adult M Adult L Adult XL Adult 2XL Adult 3XL

EMAIL: _____ CELL PHONE NO: _____

CHURCH YOU ATTEND: _____ CHRISTIAN? _____ BAPTIZED? _____

MEDICAL HISTORY

Allergic Reactions to: Aspirin____ Penicillin____ Insect bites____ Food____ - Specify_____

Other allergies: _____

Operations or serious injuries we should be aware of: _____

Date of last tetanus toxoid immunization: _____

Check if you have: Sinus Trouble___ Heart Trouble___ Asthma___ Hay Fever___ Epilepsy____ Diabetes___

Do you have any physical limitations? _____ If yes, please explain: _____

AUTHORIZATION AND PERMISSION FORM

I hereby authorize medical assistance and/or surgical treatment in the event of an emergency for the above named participant by physician chosen by the director of the event. Every effort will be made to contact you in the event of an emergency.

I give permission for the person named above to participate in all activities (*including outdoor field activities, Archery, Swimming and Water Balloon Games*) of this event and **to have his/her photo and/or video taken and used for various publications and promotions** (i.e., Hawaii Baptist Newspaper, Hawaii Pacific Baptist web site): **Yes**_____ **No**_____

I will not hold Hawaii Pacific Baptist Convention or Puu Kahea Conference Center and its staff responsible for accidents which may occur. Adequate supervision will be provided at all times.

I can be reached at: HOME PHONE: _____ WORK PHONE: _____ CELL_____

Insurance Company: _____ Policy Number: _____

Name of Physician: _____ Telephone No. _____

In the event of an emergency and I am unable to be reached, please notify:

_____ at _____ Relationship:_____

Date: _____ Signature of Parent or Guardian: _____

Print name of Parent or Guardian signing this form: _____