Northwest Youth Camp Registration

Please bring this form to camp with you.

Suggested donation: $50

Make checks payable to “Christian Youth”

For more information contact us at cog7thdayyouth@gmail.com

Camper’s name: __________________________ Gender: M F Age ______________________

Address: ____

E-mail: ____

Parents’ phone: (Home)__________________(Work)________________(Cell)________

Church Attending: _______________________ Pastor’s Name and Phone: ______________

2nd Emergency Contact: ________________________ Phone: ________________________

Camp Medical Release

Medical Information:

1. Does your child have chronic medical problems? Yes _____ No ______ Please list any allergies (bee sting, medication, etc.)_____________________________

2. Does your child take any medication? Yes_____ No_____ If yes, list name of medication and condition taken for. ____

Insurance:

The Church of God does carry limited insurance, but the following information may be needed and may speed treatment to your child should it become necessary.
Insurance: Yes______ No ______ If yes, please supply the following information:

Name of Insurance Company___________________ ID/Policy # _________________________

Name of Person Insured ______________________ Group # ____________________________

Authorization of consent to the treatment of a minor.

(I or We) the undersigned parent(s) or legal guardian of _________________________________, a minor, do hereby authorize General Council representatives or The Christian Youth board members as an agent for the undersigned, to consent to and authorize X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medical

Practices Act on medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given, in advance of any specific diagnosis, treatment or hospital care being required, to provide authority and power on the part of the aforementioned physician in the exercise of his/her best judgment.

(I, We) hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of said minor to the above named agent upon the completion of treatment.

(I, We) understand and agree that payment of any medical or dental care is (my, our) responsibility.

__________________________________ ______________

Parent or Legal Guardian Date

__________________________________ ______________

Parent or Legal Guardian Date