2022 BCBA CAMP COUNSELOR REGISTRATION & RELEASE FORM

July 10–14, 2022

Please print clearly

Counselor's Name: _____

Age: _____ DOB: _____/ _____/ _____ Counselor's Gender (Circle): Male Female

Phone: ( ) _____ Sponsoring Church: _____

Address: _____ City: _____

State: _____ Zip: _____

T-Shirt Size (please circle): **Adult or Child: Small – Medium – Large – XL – 2X – 3X – 4X**

Email: _____

Counselor's Health Information: Are you currently taking any medications or treatments: Yes / No (If yes, please list and explain) _____

_____

Date of last tetanus toxoid immunization: Month/Year: _____

Any restrictions on sports or swimming: Yes / No (If yes, please list and explain) _____

_____

Food Allergies: _____

Drug Allergies: _____

Please check any that apply: Sinus Trouble_____ Heart Trouble_____ Epilepsy_____
Asthma_____ Hemophilia _____ Arthritis_____ Diabetes_____ Other (please list) _____

Insurance Information: *Please attach a copy of your health insurance card.*

Policy Holder's Name: _____
Employer: _____
Insurance Company: _____ Group/I.D. #: _____
Physician: _____ Phone: _____

Emergency Contact Information:

Name: _____ Relation: _____ Contact Phone: _____

Name: _____ Relation: _____ Contact Phone: _____

Authorization to participate and seek emergency medical care:

I agree to hold harmless and indemnify the BLACK CREEK BAPTIST ASSOCIATION, its directors, employees, and agents, for any liability sustained through the willful, intentional, or negligent acts of the participant. Furthermore, I assume all risk for ourselves, or my child, of personal injury, sickness, death, damage, and expenses as a result of participation in the activities sponsored through the BLACK CREEK BAPTIST ASSOCIATION during kids camp July 10 – 14, 2022.

If I am unable to give my authorization, I hereby authorize any adult to consent to any and all types of medical diagnosis and/or treatment, to consent to any X-ray examination, anesthetic, medical, or surgical treatment, and hospital care or dental diagnosis. I assume responsibility for any medical bills incurred. Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, I hereby assume all transportation costs.

_____ /_____ / _____

(Counselor Signature) (Date Signed) (Counselor Contact Number)