

Navajo Work Camp Registration Form

(Please Print)

RETURN WITH FULL PAYMENT 1290 Enterprise Dr
TO CHRISTIAN CHURCH IN VA LYNCHBURG, VA 24502
(CCINVA) PHONE: 434-846-3400

Please Print:

Name: _____
 Preferred Name: _____
 Address: _____
 City _____ State _____ Zip _____
 Telephone () _____ Home() _____ (Work)
 Cell # () _____ Email: _____
 Date of Birth: ____/____/____ Age _____
 Gender: M F If Youth, Grade entering in Fall 2010: _____
 Name and address of your church: _____

**DEADLINE: MAY 31st, 2010. \$100 DEPOSIT TO HOLD
 A SPOT DUE MARCH 31st, 2010.**

**MUST COMPLETE EMERGENCY MEDICAL
 INFORMATION ON BACK!!!**

**PARTICIPANTS ARE NOT REGISTERED UNTIL A COMPLETED
 REGISTRATION/HEALTH FORM
 AND FULL PAYMENT OF FEES ARE RECEIVED!!!!!!**

BEHAVIOR COVENANT

1. No firearms or weapons (including air rifles, paint ball guns, fire-works or knives) are permitted.
2. No alcoholic beverages of any type are permitted.
3. No illegal drugs are permitted. Prescription drugs are to be brought in the original container.
4. Shoes are to be worn at all times. Closed toed shoes only will be worn on worksites.
5. Destruction or defacing of property is prohibited. Anyone responsible for such destruction or defacing is responsible for payment of repair or replacement.
6. Obscene, offensive language or obscene or offensive printing on clothing will not be allowed. All underwear must be covered.
7. No abusive language is permitted.
8. Navajo Reservation etiquette must be followed at all times (this will be provided in the confirmation letter).

*****ALL SIGNATURE BLANKS MUST BE COMPLETED.*****

I, _____, have read the Behavior Covenant Form and I agree to abide by the rules stated on the form.

Participant's Signature _____

For Participants Under the Age of 18:

I give permission for photographs taken of my child to be used in camp promotional material (brochures, videos, website, newsletter.)

Parent's signature _____ *****

The Christian Church in Virginia does not discriminate on any basis including age, sex, color, race, creed, national origin, religious persuasion, marital status, political belief or disability.

For Office Use Only: Check # _____ Amount \$ _____ Rec'd _____
 Check # _____ Amount \$ _____ Rec'd _____
 Check # _____ Amount \$ _____ Rec'd _____
 Amount Due: \$ _____

EMERGENCY MEDICAL INFORMATION

Is any medication being taken now? Yes No. If yes, complete the following.

<u>Name of Medication</u>	<u>Reason</u>	<u>Dosage</u>	<u>Time</u>

If medication is prescribed it must accompany camper to camp **IN ITS ORIGINAL CONTAINER.**

INSURANCE INFORMATION

The Christian Church in Virginia provides *liability* coverage *only* for accidents at camp. Information on participant's insurance is needed. If the participant is not covered please check in the space below and sign. Your signature verifies your responsibility for any medical expenses incurred due to illness at this event. ****PLEASE ATTACH A COPY OF INSURANCE CARD****

Name of Insurance Company _____
 Company Address _____
 Name of Member _____ ID # _____
 Group# _____
 Phone No. for Verification _____
 SSN of Camper _____
 Referring Physician _____
 Camper has no Insurance _____ Signature _____ Parent/Guardian _____

The Christian Church in Virginia will file for primary coverage if injured due to accident while participating at Camp. Craig Springs will not file claims with camper's insurance company for medical reimbursement due to illness or accident.

PLEASE NOTE: THE REGION'S INSURANCE DOES NOT COVER ANY PRE-EXISTING CONDITION. ALL ACCIDENTS OR ILLNESSES MUST BE REPORTED TO THE DIRECTOR AND THE FACILITIES MANAGER AT THE TIME OF OCCURRENCE!

EMERGENCY AUTHORIZATION (IF UNDER 18): I hereby give permission to the medical personnel selected by the director to give emergency medical treatment to my child in case of an accident, injury, illness, or routine care as deemed necessary by the camp nurse or director in charge.

Signature of Parent/Guardian _____
Date _____

EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details)

Asthma _____ Heart Trouble _____ Dentures _____
 Diabetes _____ Bed Wetting _____ Convulsions _____
 Bleeding _____ Contact Lenses _____ Fainting Spells _____
 Developmental issues _____

Explain _____

If Asthma: Will you be bringing an inhaler? _____

Date of most recent complete examination _____ Date _____ Year _____

Are you aware of any current health problems? Yes No _____
If yes explain: _____

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? Yes No _____

Date of most recent Tetanus immunization
(Must have current Tetanus shot [within last 10 years] to be considered registered.**)**

HAS IT EVER BEEN NECESSARY TO:
Restrict activities for medical reasons? Yes No _____

If yes, explain _____

Date Hepatitis series completed if applicable: _____

Additional Information the director or nurse should know including special dietary needs, emotional needs or instruction for medication: _____

Allergic to the following:
Medications: _____

Other _____