

## COVENANT POINT CAMP & RETREAT CENTER REGISTRATION – 2012

Please indicate the camp(s) for which you are registering and fill in the Participant's information below:

- Courageous Men (# of sons \_\_\_\_ x \$90): May 4 - 6, 2012 \$125.00
- Women's Relax and Craft Weekend: June 22 - 24, 2012 \$110.00
- \*\*Mom, Dad, Me (Entering Grades 1 - 3): July 13 - 15, 2012 \$90.00 each
- \*\*Sr. High Float Trip (Completed Grades 9 - 12): July 17 - 19, 2012 \$175.00
- \*\*Elem. Adventure (Entering Grades 3 - 6): July 23 - 27, 2012 \$250.00
- \*\*Mid-High Camp (Entering Grades 7 - 9): July 30 - Aug 3, 2012 \$250.00
- Family Camp (# in attendance \_\_\_\_ x \$75): Sept 14 - 16, 2012 \$200.00 max

Name(s) \_\_\_\_\_  Male  
 Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade Fall 2012 \_\_\_\_\_

Address, City/State/Zip \_\_\_\_\_

Home Church \_\_\_\_\_

Parent/Contact's Name \_\_\_\_\_

Phones: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

T-Shirt Size: **Youth:**  YS  YM  YL **Adult:**  S  M  L  XL  XXL  XXXL

Roommate Request \_\_\_\_\_  
**(You may request only one roommate and you must also be requested by that participant)**

**I give permission for my child/me to participate in all regular camp activities and for pictures taken of me and/or my child during camp to be used for camp publicity, including on the camp website.**

Participant/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

### **Mom, Dad, Me and Family Camp - Adult Registration**

Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Phones (if different from above) \_\_\_\_\_

Emergency Contact for Adult \_\_\_\_\_ Phone \_\_\_\_\_

Adult Size T-Shirt:  S  M  L  XL  XXL  XXXL

[MUPcamp@gmail.com](mailto:MUPcamp@gmail.com) or Return to:

\*\*For youth camps be sure to complete  
and send Health Release with Registration

**Covenant Point Camp and Retreat Center  
3492 Camp Keown Road  
Holts Summit, MO 65043**

## HEALTH INFORMATION AND RELEASE

**\*\*\* Photocopy of front and back of HEALTH INSURANCE CARD and PRESCRIPTION CARD must be returned with this form.**

Name: \_\_\_\_\_ Age \_\_\_\_\_

Sibling(s) if attending Same Week: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

MOM'S PHONES - Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

DAD'S PHONES - Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Name of the Family Doctor or Clinic: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Ophthalmologist/Optomtrist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Health insurance carrier: \_\_\_\_\_ Policy/Group No. \_\_\_\_\_

ACCIDENT INSURANCE is included in the camp fee, up to a set limit.

Any doctor or druggist bills incurred as a result of illness will be mailed directly to the parent/participant.

Operations or serious injuries (dates):

Chronic or recurring illness or medical condition: (Check all that apply and explain info we would need to know)

- Diabetes \_\_\_\_\_
- Seizures or Epilepsy \_\_\_\_\_
- Asthma /Allergies \_\_\_\_\_
- Reaction to Bee or other Insect stings or bites \_\_\_\_\_
- Other conditions of which we should be aware \_\_\_\_\_

**Please submit a physician's statement regarding any condition which may limit participation at camp)**

Medical Diet Restrictions:

**Current Prescription Medications:** (Please list drug and dosage; at registration for youth programs these will be checked-in to the Camp Nurse for supervision and distribution throughout the program as required.)

**If Female: Has she menstruated?** NO, has she been told about it? NO / YES / **YES**, is menstrual history normal? NO / YES

### **IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE**

To my knowledge, this health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange related transportation for me/my child. In the event I cannot be reached in an emergency, I also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Participant/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_