



Please use a separate registration form for each camper

Sixth Grade Camp Registration Form

School: Foothills Christian
Camp Dates: March 2-5, 2010
Contact: Kacy Smith (619) 561-2291
kacy35@cox.net

Name: _____ M F Birth date: _____/_____/_____

Home Address: Street _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Age _____ Grade _____

Parent/Guardian Information

Name _____ Name _____

Relationship _____ Relationship _____

Home Phone (_____) _____ Home Phone (_____) _____

Work Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Cell Phone (_____) _____

Calculate Payment:

Optional Activity Choice:

Paintball \$15.00

\$ _____ - 6th Grade Camp Fee

\$ _____ Optional Paintball Activity Amount (\$15)

\$ _____ TOTAL

RELEASE, WAIVER, AND INDEMNITY AGREEMENT

For and in consideration of permitting _____ ("my child") to observe, or use any facility or equipment of Shiloah Springs Bible Retreat, Inc. d/b/a "Indian Hills Camp" ("IHC"), or engage in and/or receive instruction in any activity or activity incidental thereto some of which may involve danger, risk of bodily injury, or death at Indian Hills Camp, I HEREBY VOLUNTARILY AND ABSOLUTELY RELEASES, DISCHARGES, WAIVE, AND RELINQUISH ANY AND ALL LOSS OR DAMAGES OR ACTIONS OR CAUSES OF ACTION FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH OCCURRING TO MY CHILD AS A RESULT OF MY CHILD'S OBSERVING OR USING FACILITIES OR EQUIPMENT OF INDIAN HILLS CAMP, OR ENGAGING IN OR RECEIVING INSTRUCTIONS IN ANY ACTIVITIES SOME OF WHICH MAY INVOLVE DANGER, RISK OF BODILY INJURY, OR DEATH OR IN ACTIVITIES INCIDENTAL THERETO WHEREVER OR HOWEVER THE SAME MAY OCCUR, AND FOR WHATEVER PERIOD SAID ACTIVITIES OR INSTRUCTIONS MAY CONTINUE. I, AS PARENT OR GUARDIAN OF MY CHILD FOR HIM/HERSELF, HIS/HER HEIRS, EXECUTORS, ADMINISTRATORS, OR ASSIGNS AGREES THAT IN THE EVENT ANY CLAIM FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH SHALL BE PROSECUTED AGAINST INDIAN HILLS CAMP OR ITS OFFICERS, AGENTS, SERVANTS, OR EMPLOYEES, THE UNDERSIGNED PARENT OR GUARDIAN WILL INDEMNIFY AND HOLD HARMLESS INDIAN HILLS CAMP AND ITS OFFICERS, AGENTS, SERVANTS, OR EMPLOYEES FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION, INCLUDING ATTORNEY'S FEES, BY MY CHILD OR BY ANY OTHER PERSON OR ENTITY, BY WHOMEVER OR WHEREVER MADE OR PRESENTED, AND UNDER NO CIRCUMSTANCES WILL I PRESENT ANY CLAIM AGAINST INDIAN HILLS CAMP AND SAID PERSONS FOR PERSONAL INJURIES, PROPERTY DAMAGE, WRONGFUL DEATH, OR OTHERWISE, CAUSED BY ANY ACT OF NEGLIGENCE BY INDIAN HILLS CAMP AND SAID PERSONS.

By signing below, I represent that I have read this release, have requested and have been provided with, or have requested and declined advisement on the potential dangers/risks of engaging in the observation, activities, or instruction offered, and am fully aware of and understands the terms and the legal consequences of the signing of this Release. I intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law and if any portion of the Release is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

In addition to the Release set forth above, as parent/legal guardian of my child I hereby grant permission to the Indian Hills Camp to take photographs of my child throughout my child's stay at Indian Hills Camp. I understand that all photographs taken of my child are the sole property of Indian Hills Camp and may be posted on Indian Hills Camp's website and promotion and advertising activities of Indian Hills Camp.

_____ Date _____ (SIGNATURE OF PARENT OR GUARDIAN)



Health History Form

Please use a separate form for each camper

Foothills Christian
Week: March 2-5, 2010
Group Leader: Kacy Smith

Child's Name _____ Birthday: ____/____/____ M F Age: _____
Parent or Guardian Name _____
Home Address: _____ City _____ St _____ Zip _____
Cell # _____ Home # _____ Work # _____

Medical Insurance (If no insurance, please indicate):

Family Health Insurance Carrier _____ Policy # _____
Doctor _____ Phone (____) _____

Immunizations

IMPORTANT: The State of California requires that every camper submit the following immunization information (month/year):

DTaP: (tetanus) ____/____ MMR: ____/____ Hep B ____/____ Varicella ____/____

**Please contact Registrar, if your child has not had immunizations.*

Had Varicella (Chicken Pox)
Please indicate month/year above

Current Health Conditions

Please mark and list all that apply

- Heart Condition ADHD Homesickness Environmental Allergies _____
- Diabetes Epilepsy Food Allergies _____
- Asthma Bed wetting Medication Allergies _____

Diet Restrictions _____
Activity Restrictions _____
Current Illness/Injury _____
Current Medications _____

Please check each box below to indicate your permission for the listed medication to be administered by the Health Supervisor.

We will not administer any medication without authorization.

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (itch, insect bite, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	Peptobismol/Kaopectate (diarrhea)
<input type="checkbox"/>	<input type="checkbox"/>	Caladryl Lotion (poison oak)	<input type="checkbox"/>	<input type="checkbox"/>	Sudafed (sinus)
<input type="checkbox"/>	<input type="checkbox"/>	Mylanta/Tums (upset stomach)	<input type="checkbox"/>	<input type="checkbox"/>	Polysporin Topical (minor cuts/burns)
<input type="checkbox"/>	<input type="checkbox"/>	Cough Drops (cough)	<input type="checkbox"/>	<input type="checkbox"/>	Robitussin (cough)
<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone Cream (itch/rash)	<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (head/muscle aches/cramps)
<input type="checkbox"/>	<input type="checkbox"/>	Claritin	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen

In a case of emergency, if parent not available, please notify:

Name _____ Hm # (____) _____ Wk # (____) _____ Cell # (____) _____
Name _____ Hm # (____) _____ Wk # (____) _____ Cell # (____) _____

Parent/Guardian Name ↓

Authorization for Treatment

Camper Name ↓

I _____, am the parent or legal guardian of _____
(hereinafter "my child"), who was born on _____ ← Date of Birth

My child is attending and participating in activities at Shiloah Springs Bible Retreat, Inc. d/b/a "Indian Hills Camp" (hereinafter "Indian Hills Camp") located at: 15763 Lyons Valley Rd. Jamul, CA 91935, in the County of San Diego.

I hereby authorize the officers, agents, servants, or employees that are 18 years of age or older of Indian Hills Camp, who supervise the activities at Indian Hills Camp into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child under Sections 6901, 6902, and 6910 of the California Family Code.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the officers, agents, servants, or employees that are 18 years of age or older of Indian Hills Camp, who supervise the activities at Indian Hills Camp to receive physical custody of my child, under Section 1283(a) of the California Health and Safety Code, upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the officers, agents, servants, or employees that are 18 years of age or older of Indian Hills Camp who supervise the activities at Indian Hills Camp.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the supervisor or his/her authorized designee, in the exercise of his/her best judgment, upon advice of such physician, dentist, and surgeon, may deem advisable.

Date (SIGNATURE OF PARENT OR GUARDIAN)