

Sacramento Assembly

2009 Camper Registration Form

(form last revised 1/1/09)

Mail to:
Sacramento Assembly Registrar
PO Box 8
Sacramento NM 88347

Phone: 575-687-3414 **Fax:** 575-687-4219

E-Mail: guestservices@sacramentoassembly.org **Web site:** www.sacramentoassembly.org

For office use only	
CC # _____	Exp _____
Check # _____	\$ _____ \$ _____ Amount this camper
Check/CC From: _____	
Date entered into database _____ by _____	

COST FOR CAMP IS \$240. YOUNG ELEM CAMP IS \$120.00 (A \$10 late fee goes into affect 2 weeks prior to each camp session and includes on site registrations) NOTE: If applicable contact us for refund information.

Registrations should be complete and signed by a pastor (or designated staff person) and parent/guardian. The registration fee must accompany the registration form or the camper will be placed on a "waiting list" until full fee is received. The signed Medical Form and registration fee must accompany the Registration Form.

Please Print Legibly

Please Print Legibly

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Camp Registering For: Young Elementary (June 12-14) \$120 Sr. High (June 22-26)
 Mid-High (June 22-26) Older Elementary (July 6-10)

Contact SMA for Sunshine camp (for mentally challenged adults) and Youth Backpacking Trips registration forms

Custodial Parent/Guardian _____ **Additional Parent/Guardian:** _____

Address _____ Address _____
Street or PO Box Number (If different from other parent)

Home Ph# (____) _____ Home Ph# (____) _____

Work Ph# (____) _____ Work Ph# (____) _____

Cell Ph# (____) _____ Cell Ph# (____) _____

e-mail _____ e-mail _____

Alternate Emergency Contact: _____ **Relationship** _____ **Phone:** _____

Camper Name _____
First (goes by) Middle Initial Last

Home Address _____
Street or PO Box Number (if different from parent) City State Zip

Birth Date _____ Gender _____ (F) _____ (M) Grade This Fall _____ Email _____

Home Church _____ Phone# _____ Circle T-shirt size (for Young Elem. Camp only) **S M L**

Church Address _____
Street or Box Number City State Zip

Pastor's Name _____ Pastor's Signature _____
(Please print)

Who will pick up camper to take home after camp _____

COMMENTS: Please list any special circumstances that might affect how the camper relates to others at camp. Examples: special dietary needs, short attention span, family or personal circumstances, etc.

Please use additional paper if more room is needed

Camp Activities at **Sacramento Assembly** may include but are not limited to: hiking in a rugged mountain setting, sports, water games, group games, archery, bikes, non-motorized push scooters, skates, ropes course and climbing wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental to the camp setting and will hold the NM Annual Conference, Sacramento Assembly and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Sacramento Assembly to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, or on the camp's web site.

Parent/Guardian's Signature _____

Don't forget to include your registration fee.....If interested in donating a Scholarship for another camper, contact SMA at 1-800-667-3414

How did you hear about us? _____ Church _____ Word of mouth _____ Media _____ Other (please note) _____

Camper Medical Form

Camper Name: _____ **Camp Attending:** _____

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. This form must be filled out to the best of your knowledge. **(A copy of a school shot record is acceptable)**

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – Haemophilus influenzae type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Influenza		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Asthma
		Food Allergies
		Other Allergies

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions or special requests _____

Activities to be encouraged or limited _____

Current medications (send with instructions) _____

(Note: Camp not usually equipped to give shots)

Suggestions on health related information for camp personnel-short attention span, etc.

For Females: Has this camper been informed about age appropriate female related health care issues? _____ yes _____ no

To The Best of My Knowledge

_____ is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility. **I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

Parent/Guardian Signature _____ Date _____

Alternate Emergency Contact: _____

Relationship: _____ Phone # _____

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company _____

Policy# _____ Group# _____

Insurance Address & Phone # _____

Family Physician Name & Phone # _____