# ALTO FRIO BAPTIST ENCAMPMENT

# Registration & Medical Release Form

*This form may be reproduced but, not altered.*

Camp Attending:_____ Camp Dates: _____ Church Attending With: _____

Camper's Name: _____ Sex: _____ Grade Completed: _____ Birthdate:_____

Address: _____ City: _____ State: _____ Zip: _____

**I have read and agree to abide by the Alto Frio Baptist Encampment Camper Rules and will cooperate with the leaders and fellow campers.**
**Camper's Signature:** _____

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Parent/Guardian Name(s): _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone Number: _____ Alternate Phone Number:_____
Family Physician's Name: _____ Phone Number: _____
Name of Primary Insurance Policy: _____ Policy Number: _____
Date of Last Tetanus Shot: _____ Is camper allergic to the Tetanus Booster? _____
Date of Oral Polio Vaccine: _____ Date of Measles/Mumps/Rubella Vaccine:_____

**Has camper had any of the following:**

Appendix Removed _____
Chickenpox _____
Fainting Spells _____
Asthma _____
Heart Trouble _____
Convulsions _____
Diabetes _____

**ALLERGIES:**

Medications: _____
Food: _____
Seasonal: _____
Other: _____

**Medication Distribution Authorization: I, _____, Parent/Guardian of _____, give the Alto Frio Baptist Encampment Nurse, EMT or Health Officer authorization to distribute the below listed prescription medications as prescribed as well as an over the counter medications deemed necessary for the treatment of my child.**

**Signed:** _____ **Date:** _____

**Prescription Medications:** **(Please attach a separate sheet of paper if taking more than 3 prescriptions)**

1. Name of Prescription: _____ Dosage: _____
   Time of Distribution: _____
   Special Instructions: _____
2. Name of Prescription: _____ Dosage: _____
   Time of Distribution: _____
   Special Instructions: _____
3. Name of Prescription: _____ Dosage: _____
   Time of Distribution: _____
   Special Instructions: _____

**Current Over the Counter Medications:** _____

**ALL MEDICATIONS MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE WITH THE CAMPER'S NAME ON THE PRESCRIPTION. NO LOOSE PILLS (INCLUDING OVER THE COUNTER) WILL BE ACCEPTED OR DISTRIBUTED.**

**Consent for Treatment:** In consideration for your agreeing to accept the above named individual as a camper, I hereby give my authority and consent to medical and surgical treatment as may be needed in the judgment of the treating physician chosen by the Alto Frio Administrator or his representative. I understand the twenty-four (24) hour first aid station is available. I further understand that limited secondary accident and illness coverage is provided.

**Photo/Video Consent:** I expressly understand and acknowledge that during the course of the camp photographs or video footage of my child may be taken and I hereby give permission for such photographs or videos to be used on the camp website and/or promotional materials for the camp.

**Parent/Guardian's Signature:** _____ **Date:** _____

**In Case of Emergency:**

Name: _____ Phone: _____

Name: _____ Phone: _____

# DIETARY INFORMATION

Alto Frio is happy to provide dietary accommodations to anyone for whom it is medically necessary.

PLEASE CHECK THE APPROPRIATE BOX BELOW

_____ I DO NOT require special dietary considerations

_____ I DO require special dietary considerations because of a medical condition

If you do require special dietary considerations for medical conditions, please list them below:

_____

_____

_____

_____

_____

_____

_____

_____