

**Lazy F Confirmation Retreat**  
**March 12 - 14, 2010**  
**Registration & Health History Form**  
**(Please Print or Type)**

**Participant Information**

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

Parent/Guardians Name: \_\_\_\_\_ Church you attend: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Emergency Contact (not parent above): \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*Accompanying Adult: \_\_\_\_\_ (One adult is requested to accompany every 6 youth from each local church. Each adult will pay just \$25.00 to cover meal costs)

**Insurance Information**

Carrier or Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Carrier's Address: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_ Policy holder's social security # or insurance ID#: \_\_\_\_\_

**Parent/Guardian Authorization** (for those under 18 years of age)

I, the undersigned parent/guardian, give permission for the above named to participate in the Confirmation Retreat. I authorize use of photos/videos for future publicity. I hereby give permission to the camp to provide routine health care, including administration of non-prescription (over-the-counter medicines) as necessary in the judgment of the health care provider or designee, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. The following health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian/participant: \_\_\_\_\_ Date: \_\_\_\_\_

**Camper's Covenant**

As a participant in the Confirmation Retreat, I, the undersigned, will cooperate with the leaders of the camp. I will involve myself with camp activities offered. I will not bring any type of weapon(s), or use of any alcohol, tobacco, or drugs (except for prescribed medical purposes). I will behave as a Christian person.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

After completing both sides of this Registration and Health History Form, along with your \$105.00 Registration Fee, (\$85.00 if postmarked before Feb 15<sup>th</sup>; and \$25.00 for adult leaders) to:

**Lazy F Camp and Retreat Center**  
16170 Manastash Road, Ellensburg, WA 98926

Phone: (509) 962-2780 Fax: (509) 962-6414  
Email: office@lazyfcamp.org

# HEALTH INFORMATION

Participant's Name: \_\_\_\_\_

**Allergies:** List all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Describe reaction and management of the reaction.

## ALLERGIES

## REACTION AND MANAGEMENT

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**MEDICATION:** Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Please bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications must be checked in to camp staff upon arrival.**

**NO Medications** on a routine basis

Medication taken as follows: Attach additional pages for more medications, if necessary.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Identify any medications taken that the camper does not/may not take during this weekend. \_\_\_\_\_

## SPECIAL NEEDS/RESTRICTIONS

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) and provide any information that will enable us to create a healthy, helpful environment for the camper. Please include: recent injuries of illnesses, medical conditions requiring treatment (i.e. surgery, overnight hospital stays, ongoing conditions, etc.), behavioral/learning challenges and suggested disciplines, emotional needs/concerns, hearing impairments, visual impairments, bedtime habits and any special routines. . .

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Please list any **dietary** restrictions (other than allergies listed above) with explanation:

Name of Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

I examined this individual on \_\_\_\_\_. (A physical exam is recommended but not required for retreat attendance.)

In my opinion, the above applicant  is  is not able to participate in an active camp program.

Comment: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tetnus  Current Date: \_\_\_\_\_

Immunizations  Current Date: \_\_\_\_\_

