MOUNTAIN VIEW BAPTIST CAMP REGISTRATION/ HEALTH FORM

Name: _____Date of Birth: _____Age:_____Male___Female___

Address:_____City/State:_____Zip:_____

Home Phone:_____Alternate Phone:_____Email(Opt):_____

Date(s) Attending:_____Church:_____Pastor:_____

Medical Insurance Company:_____Policy#_____

Medications Being Taken:_____

Medical Allergies:_____Food Allergies:_____

Blood Type (If known):_____Date of Last Tetanus: _____

In case of an accident or other emergency, I hereby grant the Mt. View Baptist Camp Superintendent permission to authorize medical attention by a physician or hospital as necessary.

Signed:_____Date:_____

Signature Required (Parent/Guardian if camper is a minor)

Sponsors Name:_____Sponsors Phone_____

PLEASE COMPLETE BOTH SECTIONS

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