

January 25-27, 2019
Ages 12-18



February 1-3, 2019
Ages 7-12

Drop off - 4 pm Friday

Pick up - 1 pm Sunday

Camper Name: _____ Church : _____

Camper Age: _____ Camper Date of birth : _____ Gender: _____

Address: _____ city _____ state _____ zipcode _____

Parent/Guardian Name: _____

Address (if different from above): _____ city _____ state _____ zipcode _____

Home Phone: _____ Email: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Authorization for Pick-Up of camper

Below are the persons allowed to pick up (Camper Name) _____.

1. _____

2. _____

3. _____

Parent/Guardian Signature : _____

\$85.00 (deposit included)

**** \$25.00 non-refundable deposit due at least one week prior to camp****

Master Card, Visa, Discover, Cash or Check

Credit Card Authorization

Signature: _____ Amount to be charged: _____

Print Name on Card: _____

Billing address: _____ city _____ state _____ zipcode _____

Card Number: _____ Card Expiration Date: _____

Medical Form



Camper Name: _____ Camper Age: _____ DOB : _____

Address: _____ city _____ state _____ zipcode _____

Parent/Guardian Name: _____

Address (if different from above): _____ city _____ state _____ zipcode _____

Home Phone: _____ Cell Phone: _____

Current or Recurring Medical Conditions : (i.e. Asthma, Diabetes, etc.)

Dietary Restrictions/Food Allergies: (i.e. Nuts, Gluten, Dairy, etc.)

Allergies: (i.e. Drugs, Environment, etc.)

Name of Camper's Physician: _____ Phone Number: _____

Insurance Company: _____ Carrier: _____

Policy #: _____ Group #: _____

Emergency Contact : other than Parent/Guardian

1. Name: _____ Relationship: _____

Phone Number: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

Phone Number: _____ Cell Phone: _____

I give permission to the Director of SBC to treat or acquire treatment from a medical professional for my child for medical reasons if I am unavailable.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____