2020 Ceta Canyon Camp Camper Registration Form

For WHOZ-WE-R

September 18-20, 2020

Fee: \$130

Mail to: Camp Registrar

37201 FM 1721 Happy, TX 79042

Phone: (806) 488-2268 Fax: (806) 488-2594

Email: info@cetacanyon.org



| VHERE | GOD IS | EXPERIENCED | AND LIVES | ARE | CHANGED. |
|-------|--------|-------------|-----------|-----|----------|
| | | | | | |

| OFFICE USE ONLY | | | | |
|-----------------|----|--------|----|-------------|
| Check #: | \$ | Amount | \$ | This Camper |
| Check From: | | | | |
| Check #: | \$ | Amount | \$ | This Camper |
| Check From: | | | | |

Parents have the option of attending Parents' Day on September 19th to participate in activities with their campers and enjoy one camp meal. The fee for this option is \$20 per parent. If you would like to attend, please circle the options below. Choose ONE meal and whether Parent #1, Parent #2, or both will be attending.

| Ke | gistration forms are NC form MUST be | • | ss all three (3) pag RENT or GUARDI | _ | S | |
|---|---|----------------------------|--|----------------------------|----------------------------|--|
| ***Please Print Legibly*** | *** F | ***Please Print Legibly*** | | | ***Please Print Legibly*** | |
| PLEASE CIRCLE IF ATTENDIN | G PARENTS' DAY: | LUNCH o | r DINNER | PARENT #1 | or PARENT #2 BOTH | |
| Camper Name | | | | | | |
| Home AddressStreet | Last | Middle Initial | First | | Goes By | |
| | | | City | State | Zip | |
| Home Phone # () | Cell # () _ | Ca | amper Email | | | |
| Gender circle one: M/F | Grade Fall 2020 | Age | at Camp | Birth Da | nte | |
| Parent/Guardian (1) | | | Email | | | |
| Address | | | | | | |
| Street or PO Box | | City | | | Zip | |
| Home Phone# () | | - | | | | |
| Parent/Guardian (2) | | | Email | | | |
| Address Street or PO Box Num | har (If different than Baront | 1) City | | State | Zip | |
| Home Phone# () | | | | | · | |
| | | | | | | |
| Alternate Emergency Contact | | | | | | |
| Church (please put the church you are c | oming with) | | City | | | |
| Please indicate if your | church is giving you a | a full or partial | scholarship and | the amount | | |
| Who will pick up camper after ca | mp? | | | | | |
| Roommate Preference (1 <u>only</u> _l | olease) | | | | | |
| | | | | ce not available for campe | rs registered onsite.) | |

Camp Activities at Ceta Canyon Camp may include but are not limited to: swimming, hiking in a rugged canyon setting, sports, water recreation, group games, 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 NWTX Conference, Ceta Canyon Camp and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Ceta Canyon Camp & Retreat Center 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.

Custodial Parent/Guardian's Signature

CANCELLATION POLICY: All camp fees include a non-refundable registration fee. A \$10 handling fee will be applied to all cancellations. Ten days from the first day of camp, the cancellation fee is half of the registration fee. Cancellations within 5 days of the start of camp WILL LOSE their full registration fee. All cancellations MUST CONTACT the Camp Registrar IN WRITING.**If interested in donating a Scholarship for a Camper, please contact Ceta Canyon at 806-488-2268.

Camper Medical Form

This Form Must Be Filled Out to the Best of Your Knowledge (A Copy of a School Shot Record is Acceptable)

Please Be Sure to Sign this Form

| Camper Name: | | Birth Da | te | |
|---|---------------------------------|--|------------------------|--|
| Cir | rcle Camp(s) Registering | For: OW 4-6 | WWR | |
| ** The following information is gathe | ered to assist us in identifyir | ng appropriate care. | Any changes to this | s form should be provided to |
| camp health personnel upon participant | 's arrival at camp. Everyth | ing must be comple | tely filled out or ev | erything will be returned.** |
| Immunization History: Ple | ease record the date (mont | h/year) of basic imm Year of Basic Immu | nunizations and mo | st recent boosters. |
| Hep B – hepatitis B | | | | |
| DTP – diphtheria, tetanus, and pertussis (or) | | | | |
| DTaP – diphtheria, tetanus, and acellular per | rtussis (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 | : Please give approximate d | ate (month/year) w | here annlicable | |
| Health Problems | Diseas | | Allergie: | s- please list all |
| Frequent Ear Infections | Chickenpox | | Hay Fever | · |
| Heart Defect/Diseases | Measles | | Ivy Poisoning, etc. | |
| Convulsions | German Measles | | Insect Sting | |
| Diabetes Bleeding/Clotting Disorders | Mumps Other | | Penicillin Other Drugs | |
| Hypertension | Other | | Asthma | |
| ,percension | | | Food Allergies | |
| | | | Other Allergies | |
| Does your child have asthma? Yes Operations or serious injuries, include dates | | | | |
| | | | | |
| Chronic or recurring illness or medical conditi | • | | | |
| Dietary restrictions or special requests | | | | |
| Activities to be encouraged or limited | | | | |
| Current medications: PLEASE COMPLETE THE | ATTACHED FORM | | | |
| Suggestions on health related information for | | tion chan otc | | |
| Suggestions on health related information for | camp personner - snort atten | tion span, etc. | | |
| | | | | |
| For Females: Has this person begun menstru | ation? Yes | No If not, has sh | ne been told about it? | YesNo |
| If so, is her menstrual history no | | | | |
| ii so, is nei menstruar nistory no | offilial: Tes | _ NO Special colls | | |
| To The Deat of Marking wiledes (c | | | to to social b | and the second transfer of the second second transfer to |
| To The Best of My Knowledge (Camper's National all camp activities with the limitation listed all | | | | |
| whatever emergency medical procedures mig | | | | |
| medical facility. I understand that should the | | • | | |
| | | | - | |
| Custodial Parent/Guardian Signature | | | _ Date | |
| | | | | |
| *How did you hear about us? Please che | ck one* Church Radio | Postcard | On-line Search | Other |
| | | | | |
| nsurance Information: Please send a c | | | | |
| Please Note: Camper's insurance coverage, t | | l as a "secondary" or " | back-up" coverage on | a limited basis to any |
| other coverage the camper has under separat | te, private, or group plans. | | | |
| | | | | |
| Medical Insurance Company | | | | |
| Policy# | | | | |
| Insurance Address & Phone # | | | | |

Family Physician Name & Phone #

Camper Medication Information

| Name of Camper (as Shown on Prescription Container): | |
|--|--|
| | |
| | |
| | |

Name of Medication and Dosage Information:

Note: All prescription medication must be in their <u>original</u> container with names and dosage clearly marked on the container. If current prescription is different from the container, then a doctor's note <u>must</u> accompany the medication when it is turned into the camp nurse.

Please Fill out the Form Below

| Medication | Dosage | Time | Special Instructions |
|------------|--------|------|----------------------|
| | | | |
| | | | |
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| Ceta Canyon receives grants from various foundations to in request demographic information, including ethnicity*. Plea | 1 1 0 |
|--|---|
| ☐ Caucasian | |
| Hispanic | |
| African American | |
| Other (Native American, Asian, etc.) | *Note: NO personal information is disclosed |