

CHICAGO MISSION CENTER YOUTH MINISTRIES

Complete the Registration Form, and Consent & Treatment Release Form and mail with your registration fees to the address given for your camp.

Make checks payable to: Community of Christ Church - Chicago Mission Center
Deposit refundable up to 7 days before camp.
Please write separate checks for each camp.



Questions: Call Kevin or Robin Henrickson at 630-896-6778 or

email Khenric263@aol.com or REHenrickson@gmail.com

REGISTRATION FORM

Yes! I'd like to come! Please register me for camp.

Name _____ Date of birth _____ Grade entering next September _____
Address _____ m - Female _____ m - Male _____
(city/state/zip) _____ Name of Camp _____
Phone _____ Date of Camp _____
Email _____ Room Mate Preference _____

Parents/Guardians Name _____

Work Phone _____ Home Phone _____

Persons allowed to pick up child from camp _____

*I promise to live by the camp rules and actively support
The program. I understand the if I violate the camps rules
I may be sent home.*

Signed by camper: _____

Date Signed: _____

CONSENT AND TREATMENT RELEASE FORM

I specifically consent to _____ participation in activities offered by the _____
Camp, including but not limited to camping, boating, swimming, hiking and sporting events. I have deleted any items from the proceeding list
to which I do not give consent for participation.

I/We certify that _____ has the necessary skills to participate in any of the approved activities (i.e. if
boating is approved, the child can swim).

I/We specifically do not want _____ to participate in the following activities: (if none, please indicate)

I, the undersigned, being the parent, legal next-of-kin, or guardian, of _____ hereby authorize any
necessary medical treatment of this person. I also guarantee payment of all charges incurred during this medical treatment. (Physician, hospital,
x-ray, lab, drugs, ambulances, etc.)

PARTICIPANT (IF 21 OR OVER)

PARENT/LEGAL GUARDIAN/NEXT-OF-KIN

DATE

HEALTH HISTORY FORM

The following information is requested so that the camp and parent can work together to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested. (Use additional paper if required.) Send fully completed form with your child. She/he will not be able to attend camp without this completed form. A copy of your medical insurance card is also necessary.

CHILD'S NAME - LAST	FIRST	SEX	DATE OF BIRTH
PARENT OR GUARDIAN'S NAME - LAST	FIRST	TELEPHONE - HOME	TELEPHONE - WORK
ADDRESS - NUMBER AND STREET	CITY-STATE	ZIP	TELEPHONE - EMERGENCY

HAS CAMPER HAD ANY OF THE FOLLOWING CONDITIONS?	YES	NO		YES	NO
1 HAY FEVER, ASTHMA, OR WHEEZING			13 MONEY TROUBLE		
2 ECZEMA OR FREQUENT SKIN RASHES			14 BRONCHITIS		
3 CONVULSIONS/SEIZURES/EPILEPSY			15 HEPATITIS		
4 HEAR TROUBLE			16 APPENDICITIS		
5 HEART MURMUR			17 MENSTRUAL TROUBLE		
6 FREQUENT COLDS, SORE THROATS, EAR ACHES (FOUR OR MORE PER YEAR)			18 RHEUMATIC FEVER		
7 MEASLES			19 SCARLET FEVER		
8 WHOOPING COUGH			20 PNEUMONIA		
9 TUBERCULOSIS			21 ANEMIA		
10 MUMPS			22 HTV		
11 CHICKEN POX			23 FRACTURES		
12 SINUSITIS			NATURE OF FRACTURES		

PLEASE EXPLAIN ANY PROBLEM AREAS IDENTIFIED ABOVE:

HAS GIRL BEEN TOLD ABOUT MENSTRUATION (ANSWER IF APPROPRIATE) m YES m NO HAS GIRL MENSTRUATED (ANSWER IT APPROPRIATE) m YES m NO

OPERATIONS OR INJURIES	HISTORY OF EMOTIONAL OR BEHAVIORAL DISTURBANCE								
ALLERGIES TO FOODS. IF NONE, SO STATE.	ALLERGIES TO MEDICATIONS. IF NONE, SO STATE.								
		POLIO	MUMPS	DIPHThERIA	TETANUS	WHOO P COUGH	MEASLES	RUBELLA	OTHER
DATE OF INITIAL IMMUNIZATION									
DATE OF MOST RECENT BOOSTER									

A PHOTOCOPY OF CAMPER'S HEALTH CARD MAY BE ATTACHED, IF ANY. PLEASE ATTACH A PHOTOCOPY OF YOUR INSURANCE CARD.

Is camper presently under a physician's care for any acute or chronic medical condition?

(If so, please explain. If none, so state.) _____

Does camper carry medications on person? (if none so state) _____

Medications _____ Purpose(s) _____

Does camper require prescription medications? (if none so state) _____

Medications _____ Purpose(s) _____

Family Physician _____ Phone _____ Address _____

Health Insurance Company _____ Phone _____ Policy # _____ Group # _____

Policy Holder's Name _____ Address _____

PLEASE ATTACH A PHOTOCOPY OF YOUR INSURANCE CARD

HEALTH HISTORY FORM (con't)

Has individual recently been exposed to a contagious disease? (If "yes", describe. If "no", so state.) _____

Does individual have problems in any of the following areas?

VISION HEARING HERNIA FAINTING DIARRHEA
CONSTIPATION SLEEP WALKING BED WETTING
RECENT EMOTIONAL UPSET (DEATH OF FAMILY MEMBER, DIVORCE OF PARENTS, ETC.) _____

Any other medical, emotional, psychological problems, dietary regime, or physical restrictions? If "yes", please describe

Permission For Medical Treatment

I, the undersigned, being the parent, legal guardian, or next-of-kin, of _____ hereby authorize any necessary medical treatment of this person. I also guarantee payment of all charges incurred during this medical treatment (Physician, hospital, x-ray, lab, drugs, ambulances, etc.)

Date _____ Parent/Guardian/Kin _____

Who To Contact In The Event Of Emergency

Name _____ Relationship _____ Phone (home) _____ Phone (work) _____

Address _____ City _____ State _____ Zip _____

Name _____ Relationship _____ Phone (home) _____ Phone (work) _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian/Kin Release Form

The undersigned parent, legal guardian, next-of-kin, or participant acknowledges dial even though every effort is made to provide a safe, accident free environment, incidents may occur.

In consideration for being accepted by the Chicago Mission Center, Community of Christ Church, for participation in this event, we (I), being 21 years of age or older, do for ourselves (myself) (and for and on behalf of my child-participant, if said child is not 21 years of age or older) hereby release, forever discharge and agree to hold harmless the aforementioned District and the Community of Christ Church and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damages and experiences of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in the above described trip or activity.

Furthermore, we (I) (and for and on behalf of our (ray) child-participant, if under the age of 21 years) hereby assume all risk of persons injury, sickness, death, damage and expenses as a result of participation in recreating and work activities involved therein. Further, authorization and permission is hereby given to said organization to furnish any necessary transpiration, food and lodging for this participant.

The undersigned further agrees to hold harmless and indemnify said organization, its directors, employees and agents, for any liability sustained by said organization as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

Only participant needs to sign if 21 years of age or older. If participant in under 21, both parents must sign unless parents are separated or divorce, in which case the custodial parent must sign.

PARTICIPANT (IF 21 OR OVER) DATE PARENT/LEGAL GUARDIAN/NEXT-OF-KIN DATE PARENT/LEGAL GUARDIAN/NEXT OF KIN DATE

Photo Release

In consideration of the right of _____ to participate in this activity, I hereby give consent to and authorize the taking of photographs and/or video tape in which my child may appear. I hereby waive all rights of privacy in and to any said pictures or tapes.

PARTICIPANT (IF 21 OR OVER) DATE PARENT/LEGAL GUARDIAN/NEXT-OF-KIN DATE