



2010 Registration & Medical Form

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FOR CAMP USE ONLY

Reg# _____

Dep
 CK CA PA CS

Use a SEPARATE form for each camp and camper.

Mail registration form, health form and a \$50 non-refundable deposit (or pay in full) for each camper to:

Prior to June 15th • Camp Christopher, 925 McKercher Drive, Saskatoon, SK S7H 4T9

After June 15th • Camp Christopher, R.R. #1, Site 7, Comp 20, Christopher Lake, SK S0J 0N0

Please provide us with the following information so that we may care for your camper to the best of our ability.

I would like to register for camp # _____ Dates: _____

Name: _____ Sex: _____ Age: _____ Gr: _____
(Completed in June)

Address: _____

_____ Postal Code _____

Health Card #: _____ Birthday (d/m/y) _____

Denomination: Presbyterian _____ United _____ Other (Specify) _____

Home Church: _____

Contact Person: _____
(parent/guardian)

Phone # Home: _____ Work: _____ Cell: _____

Other Emergency Contact: _____ Relationship: _____

Phone # Home: _____ Work: _____ Cell: _____

Does the camper receive any medication? YES NO

Condition/Illness	Medication	Dose	Time of Day

ALL MEDICATION MUST BE GIVEN TO FIRST AIDER IN ITS ORIGINAL PACKAGING ON OPENING DAY.

Date of last booster: _____

My daughter has been told about menstruation: YES NO

Continued Over





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Please check (✓) if your camper is subject to or has had the following:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Migraines | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Shyness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fear of Dark |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Homesickness | <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anxiety | | | |

Information About/Special Treatment for Conditions: _____

Does your child have any known allergies? YES NO

Drugs Food Stings Other Allergy to: _____

Reaction/Treatment: _____

***Camp Christopher greatly appreciates food donations on opening day and during the summer. We would like to donate (nut-free please):

Fresh Produce: _____ Cookies: _____ Muffins: _____ Other: _____

I permit Camp Christopher, in the event of accident, injury or illness, to authorize on my behalf all medical and other procedures including admission to hospital and all other necessary treatment deemed essential for the care and well being of the above camper. Every effort will be made to contact family should an emergency arise. I also understand that having taken such precautions as in our discretion are deemed advisable, Camp Christopher shall not be held responsible for any accident or illness involving my/our child. I authorize Camp Christopher to use any photographs taken of my child while participating in Camp Christopher programs for future promotional materials.

Signature of Parent/Guardian: _____ **Date:** _____

Please keep us informed of Camp Christopher news and events via email.

Email address: _____