CAMP AURA
REGISTRATION FORM

NAME:_____ AGE:_____

ADDRESS: _____

_____

CITY:_____ STATE:_____ ZIPCODE:_____

HOME PHONE:_____ WORK PHONE: _____

PARENT'S NAMES:_____

CHURCH NAME: _____

PASTOR'S NAME: _____

MEDICAL INFORMATION AND AUTHORIZATION

Camper's Name:_____ Age:_____ Date of Birth:_____

Address:_____

Special Medication (be specific):_____

Allergic Reactions: Bee Stings Penicillin Other:_____

Type of Reaction:_____

_____

Treatment Given:_____

Physical Handicaps, Disorders, or Diseases (include infectious diseases):_____

Restricted Activities (include reason):_____

Date of Last Tetanus Shot:_____ (Tetanus shots should be up-to-date).

Insurance Company:_____ Policy No._____

Address:_____ Phone:_____

Medical Authorization

In case of Medical Emergency, I hereby give my permission to the staff member in charge to:Hospitalize, and/or secure the services of a liscensed physician, surgeon, or anesthetist in providing the necessary care for my child as named on this application. I certify that my child is in good physical condition, and is able to participate in the entire camping program except for the activities listed as "restricted."

Signature of Parent or Legal Guardian:_____Date:_____

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