

Camping/Retreat Registration Form For Adults / Families

All attendees of South Central States Mission Center are **required to pre-register**. Your registration options are:

Reunion: Leslie Brooks, 3028 CR 2700 Independence, KS 67301 email: lbrooks@cofchrist.org cell: 620-331-9294

Event Selection			
Ozark Camp & Retreat Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> July 5 th – 11th	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Camper and Contact Information			
Name:			
Full Address Required for Income Tax Receipts		City / State	Postal Code
Address			
Home Phone:	Mobile:	E-mail:	
How did you hear of this event? <input type="checkbox"/> Community of Christ member <input type="checkbox"/> Other (please specify)			
Preferred Accommodation: <input type="checkbox"/> Founders <input type="checkbox"/> Cabin <input type="checkbox"/> Campsite (Note: campsites will be assigned. Please check-in upon arrival)			
Family Members with you (immediate family only):		<input type="checkbox"/> Adult OR Age _____ (if under 18)	
Name:		Entering Grade:	
		Relationship to you:	
Name:		<input type="checkbox"/> Adult OR Age _____ (if under 18)	
		Entering Grade:	
		Relationship to you:	
Name:		<input type="checkbox"/> Adult OR Age _____ (if under 18)	
		Entering Grade:	
		Relationship to you:	
Name:		<input type="checkbox"/> Adult OR Age _____ (if under 18)	
		Entering Grade:	
		Relationship to you:	
Name:		<input type="checkbox"/> Adult OR Age _____ (if under 18)	
		Entering Grade:	
		Relationship to you:	
		Total Registration Fees: \$ _____	
		Deposit: -	
		Amount due on arrival: \$ _____	
Signature		Date	

Donations / Registration Fees

Registration fees are for a per day basis which will include; campground rental (electric, water, etc.), meals and housing.

Reunion : July 5th – 11th registration fees is: Ages 4 – adult \$200.00

We also have a day fee of: age 4 – adult \$10.00 (plus meals are \$9 each).

Children under 4 years of age is free

These are suggested prices are based on past and expected expenses. Prices have not been adjusted for several years while costs have gone up. Help is available and no one should feel they can't come to reunion because of cost. At the same time, we encourage everyone to be prayerful about their attendance and recognize that this may involve some sacrifice if they feel strongly about attending reunion.

In order to make these events possible, those who attend events and those who feel passionate about events can make donations to cover the costs incurred. All donations can be made at Registration, given at the Congregation level or mailed to the Reunion Chair. A charitable tax receipt will be issued for the donation amount.

Privacy Policy

We respect your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting privacy. We do not rent, sell, or trade our mailing lists. The information you provide will be used to deliver the services related to the camp, retreat, or other functions for which you are registering. If you have questions about the collection or use of this information, please contact the South Central States Mission Center, Leslie Brooks lbrooks@cofchrist.org or 620-331-9294. If, at any time, you wish to be removed from any of these contacts, you can do so by phoning Leslie Brooks and we will accommodate your request.

I have read the Privacy Policy of Community of Christ and, by my signature below confirm I understand the information I provide will not be shared with any outside party as outlined above.

Release and Waiver of Liability

I understand attendance at camp/retreats involves certain risks and dangers, not all of which can be listed here. Amongst the more obvious and frequent are hazards in connection with movement about the camp/retreat and over uneven terrain; hazards in connection with camp/retreat sporting activities; hazards in connection with travel to and from the camp/retreat; hazards in connection with the use of camp/retreat buildings and facilities.

I am not relying on any oral or written statements made by Community of Christ or by anyone representing it, whether such representations are contained in brochures or media form or in individual conversation, to lead me to become involved in the camp/retreat program for which I have applied on any basis other than my assumption of the risks and dangers involved.

I have read Release and Waiver of Liability. By my signature below, I confirm my understanding of the information and personally accept all risks and dangers and the possibility of death, personal injury, property damage and loss resulting from my attendance at camp/retreat. The risk is accepted for any cause whatsoever on the part of Community of Christ or its employees, agents or representatives.

Photo Release

In consideration of the right to participate in this activity, by my signature below I hereby give consent to and authorize the taking of photographs or videotapes in which I may appear. I hereby waive all rights of privacy in and to any said pictures, videotapes or web page.

Signature

Date:

Medical Information – Complete a Separate Form for Each Family Member

This medical information is required to help ensure your health and safety while participating in the camp, retreat, or activity for which you are registering. The information is confidential and will be held in strict confidence. It will be shared only with qualified first aid or medical personnel if required. It will be retained for up to twelve (12) months and then destroyed. If you have questions about the collection or use of this information, please contact Leslie Brooks at 620-331-9294 or lbrooks@cofchrist.org.

Name:	*Health Card No.
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Family Physician:	Phone
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Allergies - food, medicine, environment (if none, so state):	
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Special Dietary Restrictions (if none, so state):

Camp Activity Restrictions: <input type="checkbox"/> None <input type="checkbox"/> Strenuous activities <input type="checkbox"/> Swimming <input type="checkbox"/> Other (describe)

Is camper currently under a physician’s care for any acute or chronic condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:

Does camper carry non-prescription medications? <input type="checkbox"/> No <input type="checkbox"/> Yes - Please list medication(s) and purpose(s):

Does camper carry prescription medications? <input type="checkbox"/> No <input type="checkbox"/> Yes – Please list dosage instructions and any other helpful information:
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Are there any medications which should not be given (i.e. Tylenol, throat lozenge, laxative, etc.):

Does camper have any history of, or is he/she being treated for the following:
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- | | | | | | | |
|--|--|---------------------------------------|---|---|--|------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Athletes’ | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive disorder | <input type="checkbox"/> Epilepsy seizures | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fractures | Foot | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous System disorder | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Skin ulcer | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Low blood pressure | | <input type="checkbox"/> Other |

If yes to any of the above, please explain:

Please check if any of the following conditions apply to the camper:
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- | | | | | |
|-------------------------------------|---------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Fainting | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Toothaches | <input type="checkbox"/> Earaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Recent emotional upset (death of loved one, divorce of parents, etc.), please explain: |
| <input type="checkbox"/> Nosebleeds | | <input type="checkbox"/> Swimmer’s Ear | | |

Please describe any other medical, emotional, mental health, dietary or physical condition which could affect the camper’s experience at camp:
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Permission for medical treatment:

The undersigned hereby authorizes any necessary medical treatment for me or the above-named (if parent/guardian). I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab, medicines, ambulance, other).

_____	Date: _____
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Signature or Parent/Guardian if camper is under 18.