

CAMP CHALLENGE REGISTRATION 2019

CAMPER INFORMATION

Name:		
Date of birth:	Age:	M / F
Address:		
City:	State:	ZIP Code:
Friend Request in Room:		

PARENT INFORMATION

Parent Name(s):		
Work:	Work Phone:	
Email:	Home Phone:	Cell Phone:

EMERGENCY CONTACT

Emergency Contact Person:		
Address:		Phone:
City:	State:	ZIP Code:

CAMP WEEK SELECTION

#1: Junior Camp (June 17-22) \$150 per camper #2 Junior Camp (June 24-29) \$150 per camper #2: Teen Camp (July 7-13) \$165 per camper	Week #:
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T- SHIRT HOODIE SELECTION

Adult: Small, Medium, Large, X-Large, Other: Junior: Small, Medium, Large, X-Large, Other:	Size:
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APPLICABLE DISCOUNT

<input type="checkbox"/> \$10 discount for 2nd child in family attending camp <input type="checkbox"/> \$10 discount for 3rd child in family attending camp <input type="checkbox"/> \$10 discount for 4th child in family attending camp	Discount:
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REGISTRATION FEES

\$ ____ Camp Week Cost	Y/ N	\$+
\$25.00 Hoodie	Y/ N	\$+
\$30 Rafting (Teens)*	Y/ N	\$+
\$ ____ For Snack Shop	Y/ N	\$+
\$ ____ Discount	Y/ N	\$+
Scholarship*	Y/ N	\$-
	Y/ N	\$-
----- *Camp Scholarship Requests can be submitted by calling camp director at 978-4049.		
----- *Consent forms must be printed from website and signed.		
		Total\$ _____

You may pay for camp online (through PayPal) by going to www.AKHABC.com and clicking the 'CAMP' tab, then the 'DONATE' button. Please put your camper's name in the comment section.

MEDICAL INFORMATION		
Camper's Name:		
Camper's Physician:	Phone:	
Insurance Company:	Phone:	
Insurance Company Address:		
City:	State:	ZIP Code:
Date of last tetanus shot:		
Medications taken regularly:		
Pre-existing medical conditions:		
Allergies/allergic reactions:		
Activities to be restricted:		
Reason for restrictions:		
CAMPER'S SIGNATURE		
I have read the general information section in the brochure and I agree to comply with the regulations while at camp.		
Camper's Signature:		
PARENT'S SIGNATURE		
In case of medical emergency, I understand every effort will be made to contact parents or guardians of campers. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize and secure proper treatment for and order injection or anesthesia or surgery for my child as named above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I also affirm that the medical information on this form is complete and correct.		
*Parent's Signature:		

* If signing form electronically, please type your name followed by the last four digits of your Social Security Number.

Please email your completed form to cindersue@hotmail.com