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U 18 Counselor Last Name: \_\_\_\_\_

**Salem Covenant Church, 215 E. Mountain Street, Worcester MA 01606**

Telephone (508) - 853 - 4071

Day Camp Counselor Registration Form for August 1 – 5, 2011

All forms *must* be in by **June 30<sup>th</sup>**

**Counselor Information:**

Full Name \_\_\_\_\_

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Grade Entering \_\_\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_

T-shirt Size: Child (circle one) S M L Adult (circle one) S M L XL 2XL 3XL

**Parent / Guardian Information and EMERGENCY Information**

Parent /Guardian \_\_\_\_\_ (print) \_\_\_\_\_ (signature)

Parent /Guardian Address \_\_\_\_\_

**Medical Information:**

\*My child has the following allergies \_\_\_\_\_

\*I authorize the Day Camp Staff to give my child the following prescriptions which are listed below which will match the label on the container given by my child's health care provider. (Initial) \_\_\_\_\_

\* \_\_\_\_\_ at \_\_\_\_\_ (time)

\* \_\_\_\_\_ at \_\_\_\_\_ (time)

\*Incase of emergency, illness or accident to the child named above, the Day Camp Staff are authorized to proceed as indicated below. Please number each 1, 2, 3, etc., in the order of desired action.

( ) Contact father at \_\_\_\_\_ (address) \_\_\_\_\_ (phone)

( ) Contact mother at \_\_\_\_\_ (address) \_\_\_\_\_ (phone)

( ) Take child to emergency hospital \_\_\_\_\_

( ) Take child to any licensed physician \_\_\_\_\_

( ) Other \_\_\_\_\_

\*I understand that every effort will be made to provide for the safety and wellbeing of my child. In the event of accident or injury, I authorize the Day Camp Staff to seek proper medical treatment. I give my permission for the use of any medical treatment required under the direction of a physician. I authorize transportation of my child by ambulance in order to facilitate any necessary treatment. I agree not to hold Salem Covenant Church or its agents liable in such matters. (Initial) \_\_\_\_\_

\*My child has the following impairments that may affect activities while at camp.

\* \_\_\_\_\_

(Form continues on back)

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**Health Care Provider (HMO) Information**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip \_\_\_\_\_

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**Other concerns** (If none, please state so.)

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**Requirements**

In order to be allowed to volunteer at Vacation Bible School your child you must also submit the following records. Volunteers will not be accepted until all records have been properly submitted within the time restraints.

- Immunization records of MMR, Polio, Diptheria, Tetanus, and Pertussis
- Physical exam completed within the last 24 months.

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**Miscellaneous Information**

- Lunches should be in a brown bag, no coolers, and brought every day.
- Please send registration forms to: C/O Camp Registrar  
Salem Covenant Church  
215 E. Mountain St  
Worcester, MA 01606
- Confirmation letters will be sent upon receipt of registration form.

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By signing below I assert that the information given is correct to the best of my knowledge.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_