

20th Annual Harvest Deaf Camp
July 26-31, 2009

Registration & Medical Form (Please Print)

Camper's Name _____ (M/F) Age _____ Deaf ___ Hearing ___

Spouse's Name _____ (M/F) Age _____ Deaf ___ Hearing ___

Address _____ City _____ State _____ Zip _____

Parent/Guardian Name _____ Home Phone (____) ____ - _____

Name of Church the camper is with _____

Child's Name

1. _____ (M/F) Age _____ Deaf ___ Hearing ___

2. _____ (M/F) Age _____ Deaf ___ Hearing ___

3. _____ (M/F) Age _____ Deaf ___ Hearing ___

4. _____ (M/F) Age _____ Deaf ___ Hearing ___

5. _____ (M/F) Age _____ Deaf ___ Hearing ___

In An Emergency, Contact:

Name _____ Phone (____) ____ - _____

Name _____ Phone (____) ____ - _____

Health History: (Please check all that apply)

Asthma Bleeding/clotting disorder Convulsions (last date) _____

ADD/HD Diabetes Swimmer's Ear Heart disorder Mononucleosis Seizure Frequent ear infection Other _____

Allergies:

Hay Fever Bee Stings Penicillin Foods _____

Other _____

Date of last tetanus _____ Booster _____ DTP _____

Activities to be limited by physician's advice _____

Current Medications: (always send with instructions in original container)

Medication _____ Reason _____

Medication _____ Reason _____

Insurance Name _____ Group/Policy # _____

Physician's Name _____ Physician's Phone (____) ____ - _____

My child may have swimmers ear prevention drops after swimming if necessary. Yes No

My child may have Tylenol for minor aches or pains. Yes No

Release of Liability: (One for each child camper)

Camper's Name _____

Date of Birth ____ / ____ / ____

I, _____, (parents / guardian) of _____, (camper under 18) give permission for my child to participate in the activities of the Harvest Deaf Camp at N.A.C.A. in Fort Bluff, TN. I release the organization and its leaders, employees, volunteers, and agents from any claim that me or my child may have against them as a result of injury or illness incurred during the course of participation in activities and that the HDC and staff have no responsibility for lost, stolen, or damaged property. I give permission for photo or video of my child to be used for promotional purposes of the deaf camp.

I recognize that there may be an occasion where the above named child is in need of first aid or emergency medical treatment as a result of accident, illness, or other health condition or injury. I do hereby give permission for agents of this organization to seek and secure any needed medical treatment for my child, including hospitalization if the need arises. In doing so, I agree to pay all costs arising from such condition. I give permission for medical personnel to administer any needed medical treatment, including surgery, and, again, I agree to pay for the medical treatment.

Signature of parent or legal guardian _____ **Date** ____ / ____ / ____

Witness signature _____ **Date** ____ / ____ / ____