Lazy F Winter Family Camp
February 12th – 14th, 2010
Registration & Health History Form

Family / Participant Information

Contact Person:____ Church you attend:__________________________________

Mailing Address:___________________________ City______________________________ State____________ Zip__________

Home Phone: (_____)___________________ Other Phone: (_____)____________________ e-mail: ________________________

Please list the people coming with your family group

	Name	Age
1)	*assumed to be Contact person above*	
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Add additional names on a separate attached page

Any lodging location requests:
(for non Skyline / Ridgeview cabins)

____

Please select your Accommodations:
Fee includes your lodging, food, and programming:

______Skyline Cabin, rooms for 4, private bath, and linen $310 / room
______Ridgeview Cabin, rooms for 4: $285 / room

All other cabins / per person rates
______1-4 people: $75 adult, $55 youth**
______5-6 people: $70 adult, $50 youth***
More than 6?: Please contact us for individually based family discounts
Adults _____ X rate $______ = _______
#Youth ______ X rate $______ = _______

**If your requested lodgings have already been reserved – we will contact you for any available spaces we might have*
***Youth= Kindergarten to High school*
****Children preschool and younger can stay for free (but we offer no individual programming for them)*

_____ **Total Fees**

Parent/Guardian Authorization (for those under 18 years of age)

I, the undersigned parent/guardian, give permission for the above named to participate in the Confirmation Retreat. I authorize use of photos/videos for future publicity. I hereby give permission to the camp to provide routine health care, including administration of non-prescription (over-the-counter medicines) as necessary in the judgment of the health care provider or designee, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. The following health history is correct and complete as far as I know. The person(s) herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian/participant:____ Date:______________________

Signature & date of additional adult participants: __________________________ __________________________

__________________________ __________________________

Please return Registration Form will $100.00 deposit and completed Health Forms to:

Lazy F Camp and Retreat Center Phone: (509) 962-2780 Fax: (509) 962-6414
16170 Manastash Road, Ellensburg, WA 98926 Email: office@lazyfcamp.org

HEALTH INFORMATION

Participant's Name:___________________

Please fill out one form per person

Name____ Phone_______________________

Address____

M_____ F______ Birth date____/_____/_______ Age________

Person to notify in case of emergency:

Name_______________________________________ Relationship__________________________
Address____
Phone (home)_________________________(work)____________________(other)___________
Will the person's emergency contact be present at Family Camp? YES_____ NO _____

MEDICAL INFORMATION

For your benefit and the safety of others, we need to be aware of any medical conditions you have that might impact your participation. All information is confidential and shared only with the camp's health care provider and program facilitator(s).

1. Are you on any medication?______ What kind?_______
2. Are you allergic to any of the following (please specify):
   Bug bites______ Medication______
   Bee stings______ Other___________

3. Do you have any **FOOD Allergies** (please list) ____

4. Do you have any limiting physical problems (temporary or permanent)? Y_____ N______
   If yes, please specify:
   _______Asthma _______Back Problems
   _______High blood pressure _______Kidney problems
   _______Low blood pressure _______Bone/joint problems
   _______Cardiac or respiratory _______Fear of heights
   _______Recent surgery _______Other

What should we know about any of the above? ____
____

Special dietary needs____

Family Medical Insurance: ____Yes ____No Name of Insured:_______________________________
Carrier:_____________________ Group#______________ Policy #___________________
Name of family physician_______________________________ Phone___________________________

I, the undersigned, have provided current, factual, and complete information on this form

Signature____ Date______________________
(Guardian, if participant is under 18 years of age)