CAMP LAKESIDE EVENT REGISTRATION FORM.

Important policy notifications: All personal information is confidential. All medical or special needs information is confidential and will only be shared on a need to know basis (i.e.; food service for special diets; emergency room personnel in case of emergency treatment.)

EVENT CHOICE

NAME OF EVENT:_____EVENT NUMBER:_____

Price: $_____ Date of Event: _____

CAMPER INFORMATION

First Name:_____Last Name:_____Preferred Name:_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____E-mail Address:_____

Cell Phone: (_____)_____ Home Church:_____

Male:___Female:___ Roomate request:_____

Please note any special session/class for your event:_____

EMERGENCY CONTACT INFORMATION (please list at least one)

Name:_____Relationship to camper:_____

City:_____State:_____

Telephone | Home: (____)_____Work: (____)_____Cell: (____)_____

Name:_____Relationship to camper:_____

City:_____State:_____

Telephone | Home: (____)_____Work: (____)_____Cell: (____)_____

PAYMENT INFORMATION

Credit Card

Circle type of card: VISA MasterCard Account#: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Exp. Date:_____/_____ Name of Card Holder:_____

Authorized Signature:_____

Check or Money Order

Please make checks or money orders payable to: Camp Lakeside
No Cash Payments Please.
All faxed or on-line registrations must be paid in full via credit card.

TOTAL PAYMENT ENCLOSED:_____

REFUND POLICY:

Full refunds will be granted for cancellations received 14 days prior to the event.
50% of registration fees will be refunded on cancellations received 13 to 7 days prior to the event.
No refunds will be granted for cancellations received less than 7 days prior to the event.
Special exceptions will be considered. Full refunds will be granted if the event is cancelled, at any time, by Lakeside staff.

CAMP LAKESIDE EVENT HEALTH HISTORY & TREATMENT AUTHORIZAION

Camper's Name_____

Event Name_____ **Event Number**: _____ **Birth date**____ /____/____

Please share any information that may be of assistance to emergency workers.

_____
_____
_____
_____

Allergies
Please list all allergies including those to food, medications and environment.

_____
_____

Dietary Needs:
Do you require special dietary considerations such as diabetic diet, low fat or GERD?

_____
_____

Mobility Needs:

_____
_____

Physician's Name:___
Phone (_____)_____

Please list all medications including supplements and over the counter medications.

_____
_____
_____
_____

I understand that camp staff need to know pertinent information about my physical health. Therefore, I have disclosed all information that could jeopardize my health and safety or the safety of others. In the event that I am unable to give express consent I give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications and seek emergency medical treatment including ordering x-rays and routine tests. I give permission to the camp to arrange necessary related transportation.
I agree to the release of any records necessary for insurance purposes. I give permission to the physician(s) selected by the camp staff to secure and administer proper treatment, including hospitalization, for the release of information regarding said medical treatment to camp staff.

Signature_____

MAIL TO
LAKESIDE: Camp Lakeside, 300 E. Scott Lake Dr., Scott City, KS 67871
SAVE A TREE: REGISTER ONLINE
If you have a computer and internet connection, save the paperwork and register for camp online: WWW.CAMPLAKESIDE.NET