



PLEASE FILL OUT THIS FORM, PRINT IT AND MAIL IT IN ALONG WITH YOUR REGISTRATION FEE (\$100) TO:

CAMP DIRECTOR
CONCEPTION SEMINARY COLLEGE
P.O. BOX 502
CONCEPTION, MO 64433

(checks payable to Companion Camp 2011)

COMPANION CAMP 2011 REGISTRATION FORM

Name: _____ Birthday: _____ Grade in fall '10: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

T-shirt size: S M L XL XXL

Waiver: We (I) hereby release all church, camp staff and adult advisors from any and all claims, loss, damage, or expense, arising out of or from any accident or other occurrence causing injury to any person or property during this camp. Furthermore we (I) assume all risks of personal injury, sickness, death, damage and expense as a result of participation in recreation and activities involved therein by our child. We (I) are the parent(s) or legal guardian(s) of this participant and grant our (my) permission for the camp directors or their duly authorized representatives to act on our (my) behalf in a medical emergency if I am unable to do so. Camp staff reserves the right to examine all camper and staff belongings to ensure a safe camp for everyone.

Signed (Parent / Guardian): _____ Relationship to child: _____

Endorsement of Parish Priest: I fully support this young man's desire to attend Companion Camp 2010. I believe him to be interested in learning more about his faith and the vocations it has to offer.

(Arch)Diocese of: _____ Parish / City: _____ Signed: _____

How many in your family (not including camper) plan to attend Sunday lunch? _____ (lunch to follow 10:30 Mass, \$5 for each person 12 and older; under 12 eat free)

COMPANION CAMP 2011 HEALTH HISTORY FORM

Does your son have any health concerns? (please check all that apply)

Diabetes Digestive Problems Asthma Epilepsy Sleepwalking Allergies Other (list below)
Specify (allergies or other concerns): _____

Does your son take any routine medications? If so, please list them as well as the time taken, and reason for taking them:

I give permission for a registered nurse on staff to administer the following medications: Tylenol for headache, pain, or fever (parents will be notified in case of fever) Benadryl for hives and rashes Antibiotic cream for cuts

In case of emergency, contact:

Name: _____ ☎ (1st): _____ ☎ (2nd): _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ ☎: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Provider: _____ Policy Number: _____