CABIN LEADER TRAINEE APPLICATION & HEALTH INFORMATION FORM

Cabin Leader Trainee Application & Health Information Form
mail form to: Camp Director, Melissa Travis
5555 - 4th Avenue NE
Calgary, AB T2A 3X9
email: rocklakecamp.bc@hotmail.com

Family Name	Given Name	Name Used

PLEASE PRINT CLEARLY

Parent ❑ or Guardian ❑ _____

Address: _____ Phone: _____

email: _____

Camper's Age _____ Grade Completed: _____ at _____ School

Has the Trainee been to camp before? YES ❒ NO ❒

COST FOR CAMP IS $75.00

REFUND POLICY:
Refunds will be given only upon receipt of written cancellation received by The Rock Lake United Church Camp Society, at the above address, at least four (4) weeks prior to the start of camp. No refunds will be given for any cancellations received less than four weeks prior to the start of camp.

I, the undersigned, acknowledge and consent to the participation of my child in the United Church Junior Camp program being held by The Rock Lake United Church Camp Society (Insert appropriate dates) at Rock Lake Camp. Details concerning this camp, including activities, travel, leadership, location and safety features have been communicated to me and are understood.

Further, this is my permission for the Official-in-Charge or his/her designate to make arrangements for necessary surgical or medical attention in the event of serious illness or injury. If such attention is required, every effort will be made to notify the parent/guardian or responsible party.

I further understand that photographs and/or videos may be made of the camp and campers to be used for publicity purposes.

_____ _____

Signature of Parent or Guardian Date

NOTE: Please complete reverse side for Medical Information.

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Camper's Medical Information:

Family Name (please print)	First Name (please print)

Emergency Contact: _____ if parent or guardian not available

Relationship: _____ Phone: _____

Physician's Name: _____

Clinic: _____ Phone: _____

Provincial Health Care Card No: _____ from province of _____

Is he/she presently under the care of a physician or receiving medical attention? Yes ❑ No ❑

If yes, please describe _____

_____

Does He/she have a Chronic Condition _____

_____

_____

Is he/she on Medications _____

_____

_____

Please list all known allergies (food, medication, insects, etc.) _____

_____

_____

Please list any food restrictions: _____

_____

Does or has he/she had?:

Rheumatic Fever ❑ Diabetes ❑ Asthma ❑ Epilepsy ❑

Are all inoculations (including COVID) up-to-date?:

Yes ❑ No ❑

If no please explain: _____

_____

Other Comments: _____

_____

_____

_____

_____ _____

Signature of Parent or Guardian Date

NOTE: Please complete reverse side for Personal Information