

# THE TRI-STATE CONNECTION Registration Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ [Circle one] Male | Female

Email \_\_\_\_\_

Pairing with: (if applicable) \_\_\_\_\_

Emerg. Contact \_\_\_\_\_ Phone \_\_\_\_\_

Church \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## MEDICAL INFORMATION

List all prescription and non-prescription meds, including dosages, frequency/administration and purpose: \_\_\_\_\_

Other health and/or behavioral considerations: \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Ins. Company \_\_\_\_\_ Policy # \_\_\_\_\_

"I hereby certify that the above information is correct and give permission for the use of photographs or videos including myself to be used in camp publicity and for the release of medical records in case of illness or injury. In the event that my emergency cannot be reached, I hereby give permission to the physician selected by Camp Selah to give emergency medical or surgical treatment and routine non-surgical medical care."

Signature \_\_\_\_\_

**REQUIRED!** Date \_\_\_\_\_

# THE TRI-STATE CONNECTION Registration Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ [Circle one] Male | Female

Email \_\_\_\_\_

Pairing with: (if applicable) \_\_\_\_\_

Emerg. Contact \_\_\_\_\_ Phone \_\_\_\_\_

Church \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## MEDICAL INFORMATION

List all prescription and non-prescription meds, including dosages, frequency/administration and purpose: \_\_\_\_\_

Other health and/or behavioral considerations: \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Ins. Company \_\_\_\_\_ Policy # \_\_\_\_\_

"I hereby certify that the above information is correct and give permission for the use of photographs or videos including myself to be used in camp publicity and for the release of medical records in case of illness or injury. In the event that my emergency cannot be reached, I hereby give permission to the physician selected by Camp Selah to give emergency medical or surgical treatment and routine non-surgical medical care."

Signature \_\_\_\_\_

**REQUIRED!** Date \_\_\_\_\_