

# 2021 CITY CAMP REGISTRATION FORM – CITY UNION MISSION

Required information is indicated with an asterisk. (\*)

Tshirt Size:

- Y-S   A-S  
Y-M   A-M  
Y-L   A-L  
          A-XL  
Other \_\_\_\_\_

Swimsuit Size

## CAMPER INFORMATION

\*Camper Name (last, first) \_\_\_\_\_

Previous Last Name (if changed) \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\*Date of Birth

\_\_\_\_\_  
Age      School Grade

\_\_\_\_\_  
Height      Weight

M \_\_\_\_ F \_\_\_\_      Age at Camp \_\_\_\_\_  
\*Gender

## PARENT/ GUARDIAN INFORMATION

\_\_\_\_\_  
\*(First Emergency Contact unless otherwise noted)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\*Date of Birth

\*Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_  
\*Phone #

(\_\_\_\_\_) \_\_\_\_\_  
Additional Phone #

\_\_\_\_\_  
Household E-mail address

## SCHOOL INFORMATION (Fall 2020)

School Name \_\_\_\_\_

School District \_\_\_\_\_

Grade \_\_\_\_\_

## CHURCH INFORMATION

Church Name \_\_\_\_\_

Pastor's Name \_\_\_\_\_

Church Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_  
Church Phone

\_\_\_\_\_  
Church Email Address

## **\*PHOTO RELEASE:**

I hereby grant permission for City Union Mission to use my child's photograph and/or video and/or information about them for the purpose of publications, promotion, or any other use they deem necessary. I understand my child's photograph/ video/information about them may be used for fundraising purposes. I understand that I cannot expect compensation for use of these photos or stories.

### **\*Please check the appropriate box and sign below:**

I **DO** give permission for my child named above to be photographed and/or videotaped during youth center activities for the purposes stated above.

I **DO NOT** give permission for my child named above to be photographed and/or videotaped during any youth center activities for the purposes stated above.

\*Parent/Guardian Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

## **Turn over to complete registration form.**

In order for this application to be processed, bring the following items to City Union Mission's Family Center, 1310 Wabash:

### **1) Completed Application 2) Proof of date of birth 3) Medical Insurance Information**

Applications accepted until spaces are filled, or until Wednesday, May 27<sup>th</sup>, 2020.  
beginning May 11, Monday-Friday, 9a-3:30p. Questions? **Call (816) 222-5058**

## MEDICAL FORM

Children with special needs are taken on a case-by-case basis.

### ADDITIONAL EMERGENCY CONTACT INFORMATION

People with whom City Union Mission can exchange emergency information and through whom a responsible party can potentially be contacted...Also, if the registrant is a minor, someone to whom he or she may be released when necessary (including scheduled pick-up time)...Finally, someone who may give permission to another individual to pick up. \*\*Information for positive ID must be provided.

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 \*Second Emergency Contact \*Cell Phone # Work Phone # \*Other Phone #  
*(Spouse/Parent/Guardian/Next of Kin)*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \*\*Date of Birth Relationship to Registrant

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 \*Third Emergency Contact \*Cell Phone # Work Phone # \*Other Phone #

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \*\*Date of Birth Relationship to Registrant

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**\*For every item below, please provide an answer or write N/A.**

**Any allergies to food or medications** (please explain) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other allergies** (specify) \_\_\_\_\_

**\*Current medications** (send in prescription bottle with instructions)

Name of Medication	Reason for Use	Dosage (if known)	Frequency (if known)

**Operations or serious injuries** (include dates) \_\_\_\_\_  
 \_\_\_\_\_

**Chronic or recurring illness or medical condition**

Y/N	Asthme	Y/N	Diabetes/Pre-Diabetes	Y/N	ADD / ADHD
Y/N	Visually Impaired	Y/N	Behaviorally Challenged	Y/N	Emotionally Challenged
Y/N	Physically Handicapped	Y/N	Hearing Impaired	Y/N	Learning Disabled
Y/N	Frequent Ear Infections	Y/N	Hypertension	Y/N	Heart Defect/Disease
Y/N	Seizures	Y/N	Bleeding/Clotting Disorder	Y/N	Frequent nose bleeds
Y/N	Bed Bug Bites	Y/N	Runner	Y/N	Other _____

### INSURANCE INFORMATION

- Insurance information attached. (Copy with waiver)  
 (Company Name, Policy Number, Policy Holder Name, Group Number, Insurance company address and phone number)
- Does not have insurance. Only waiver is attached.

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