

Faith & Fellowship Youth Camp
c/o Open Bible Tabernacle
Attn: Karen Darrough
545 Lorene Drive
Marietta, Georgia 30060

Fee: \$150.00



Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Church Home: _____

Pastors Signature: _____

Emergency Telephone Number(s): _____

Parents Cell Number(s): _____

Nearest Living Relative not living with you: _____

Phone number: _____

NOTE: No one under the age of 9 is allowed at camp unless accompanied by parent that will be a worker. All children under the age of 9 must be cleared with the Camp President or Director before arrival. Space and beds are limited so campers will be given 1st priority. Children under the age of 9 must stay with parent at all times and will be charged \$20.00 for food expenses. Please complete a non-camper registration

Medical Information

Chicken Pox **Scarlet Fever** **Measles** **3-day Measles** **Mumps**

Rheumatic Fever **Hepatitis** **DPT (Tetanus) Date:** _____

Is camper on any medication? **Yes** **No**

If yes, what is the name of the medication? _____

Dosage instructions: _____

Camper has had problems with : **Heart** **Ears** **Bed wetting**
 Skin **Asthma** **Tonsils**

Does camper have any allergies to medicine? **Yes** **No** **If yes, please list below:**

I hereby give my permission for my child to participate in the camp program. I understand that neither the camp nor the insurance company will be responsible for medical treatment or liability resulting from physical conditions existing prior to my child coming to camp. I give my permission for treatment by a doctor in case of sickness or accident.

Required Parent/Guardian Signature: _____

Faith & Fellowship Youth Camp
c/o Open Bible Tabernacle
Attn: Karen Darrough
545 Lorene Drive
Marietta, Georgia 30060

[Fee: \$20.00]



Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Church Home: _____

Pastors Signature: _____

Emergency Telephone Number(s): _____

Parents Cell Number(s): _____

Nearest Living Relative not living with you: _____

Phone number: _____

NOTE: No one under the age of 9 is allowed at camp unless accompanied by parent that will be a worker. All children under the age of 9 must be cleared with the Camp President or Director before arrival. Space and beds are limited so campers will be given 1st priority. Children under the age of 9 must stay with parent at all times and will be charged \$20.00 for food expenses. Please complete a non-camper registration

Medical Information

Chicken Pox **Scarlet Fever** **Measles** **3-day Measles** **Mumps**

Rheumatic Fever **Hepatitis** **DPT (Tetanus) Date:** _____

Is non-camper on any medication? **Yes** **No**

If yes, what is the name of the medication? _____

Dosage instructions: _____

Non-Camper has had problems with : **Heart** **Ears** **Bed wetting**
 Skin **Asthma** **Tonsils**

Does non-camper have any allergies to medicine? **Yes** **No** **If yes, please list below:**

I hereby give my permission for my child (non-camper) to participate in the camp program. I understand that neither the camp nor the insurance company will be responsible for medical treatment or liability resulting from physical conditions existing prior to my child coming to camp. I give my permission for treatment by a doctor in case of sickness or accident.

Required Parent/Guardian Signature: _____

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**• Fee:
Love Offering**



Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Church Home: _____

Pastors Signature: _____

Emergency Telephone Number(s): _____

Emergency Cell Number(s): _____

Nearest Living Relative not living with you: _____

Phone number: _____

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Medical Information

Chicken Pox **Scarlet Fever** **Measles** **3-day Measles** **Mumps**

Rheumatic Fever **Hepatitis** **DPT (Tetanus) Date:** _____

Is worker on any medication? **Yes** **No**

If yes, what is the name of the medication? _____

Dosage instructions: _____

Worker has had problems with : **Heart** **Ears** **Bed wetting**
 Skin **Asthma** **Tonsils**

Does worker have any allergies to medicine? **Yes** **No** **If yes, please list below:**

I understand that neither the camp nor the insurance company will be responsible for medical treatment or liability resulting from physical conditions existing prior to my coming to camp. I give my permission for treatment by a doctor in case of sickness or accident.

Signature _____

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**• Fee:
\$3.00 per meal**



Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Church Home: _____

Pastors Signature: _____

Emergency Telephone Number(s): _____

Emergency Cell Number(s): _____

Nearest Living Relative not living with you: _____

Phone number: _____

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Medical Information

Chicken Pox Scarlet Fever Measles 3-day Measles Mumps

Rheumatic Fever Hepatitis DPT (Tetanus) Date: _____

Is visitor on any medication? Yes No

If yes, what is the name of the medication? _____

Dosage instructions: _____

Visitor has had problems with : Heart Ears Bed wetting
 Skin Asthma Tonsils

Does visitor have any allergies to medicine? Yes No **If yes, please list below:**

I understand that neither the camp nor the insurance company will be responsible for medical treatment or liability resulting from physical conditions existing prior to coming to camp. I give my permission for treatment by a doctor in case of sickness or accident.

Visitor Signature: _____