



www.redlinestudentevents.com

**June 24-28, 2013**

**Fort Bluff Camp**  
Dayton, TN

**Free Time Options:**

- 250 ft. Water Slide
- Archery
- Lake Blob and iceberg
- Basketball, Tennis
- Sand Volleyball
- Miniature Golf
- Paintball
- Ropes Course
- Hiking and fishing

**Worship** with David Glenn Band

**COST \$350**

Registration and \$50 Deposit Due May 5

**BALANCE DUE JUNE 9**

**Need more info?**

Contact Chris Britton at 356-3076 or  
chris@centeringlives.com

# REGISTRATION

☐ Male ☐ Female Grade \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Ph \_\_\_\_\_

Cell Ph \_\_\_\_\_

Email \_\_\_\_\_

T-Shirt Size (circle one) S M L XL XXL

**Parent(s) Info**

Name \_\_\_\_\_

Work Ph \_\_\_\_\_

Cell Ph \_\_\_\_\_

Email \_\_\_\_\_

**Emergency Contact if not parents**

Name \_\_\_\_\_

Relation \_\_\_\_\_

Home Ph \_\_\_\_\_

Cell Ph \_\_\_\_\_

**For Office Use Only**

Deposit Rcvd \$ \_\_\_\_\_ Date \_\_\_\_\_

☐ Cash ☐ Check # \_\_\_\_\_

Balance Rcvd \$ \_\_\_\_\_ Date \_\_\_\_\_

☐ Cash ☐ Check # \_\_\_\_\_

☐ CP Medical Form ☐ Ft Bluff Medical Form

Centerpoint Fellowship Church  
**MEDICAL HISTORY AND RELEASE FORM**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
(Street, City, State, Zip Code)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

In Emergency Notify (If Parent or Guardian cannot be located) \_\_\_\_\_

Relation \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Allergies (Check those that apply) If yes, give full details.

Hay Fever, etc \_\_\_\_\_ Poison Ivy/Oak/Sumac \_\_\_\_\_

Insect Stings \_\_\_\_\_ Penicillin \_\_\_\_\_

Aspirin \_\_\_\_\_ Foods \_\_\_\_\_

Other \_\_\_\_\_ Can your child take Tylenol? ☐ Yes ☐ No

Are Immunizations up to date? \_\_\_\_\_ If no, explain \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_ Date of Last TB Skin Test \_\_\_\_\_

List any medication or drugs taken regularly (presently or recently) \_\_\_\_\_

Do you wear Contact Lenses? ☐ Yes ☐ No

Activity Limitations? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Other Information for Chaperones or Church Leaders

## IMPORTANT – THE INFORMATION BELOW MUST BE COMPLETED FOR ATTENDANCE

The Health History is correct so far as I know, and person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization – I hereby give permission to the medical personnel by Centerpoint Fellowship Church's staff or church leaders to order X-rays, routine tests and treatment for my child that he or she may deem necessary. In the event of an emergency and I cannot be reached, I hereby give permission to the physician or other health care professional selected by Centerpoint Fellowship staff or church leaders to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child as named in this document. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company. I will pay for any medical expenses so incurred. I will notify the church if I feel there are any health considerations that would prevent my child's participation in any activity. I also give my permission for church leaders to restrict my child from participation in any activity, which they have any questions about for health or other reasons.

As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by Centerpoint Fellowship Church for the calendar year 2013. I fully release Centerpoint Fellowship Church, its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action, which might be asserted, in our behalf against said church, representatives or staff.

\_\_\_\_\_  
Date \_\_\_\_\_  
PRINT Name of Parent/Guardian

\_\_\_\_\_  
Date \_\_\_\_\_  
Signature of Parent/Guardian

I \_\_\_\_\_ understand and agree to abide with the restrictions placed on my activities by  
Child's Name  
my parent/guardian.

\_\_\_\_\_  
Signature of Child/Youth Participant

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### INSURANCE

Name of Child \_\_\_\_\_

Insurance issued in the name of: \_\_\_\_\_ Is this coverage for a dependent? ☐ Yes ☐ No

Address of Insured: \_\_\_\_\_  
Street or Box City State Zip

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_  
Street or Box City State Zip

Preauthorization Phone # \_\_\_\_\_

## FORT BLUFF CAMP

370 Fort Bluff Camp Road | Dayton, TN 37321 | Office 423.775.0488 | Fax 423.775.1968

### HEALTH FORM

**EVERYONE** (Students, Sponsors, and Onsite Lodging Guests) **must complete a Health Form**

NAME \_\_\_\_\_

SCHOOL \_\_\_\_\_

HOME ADDRESS (CITY, STATE, ZIP) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PHONE NUMBERS (INCLUDE AREA CODE) \_\_\_\_\_

HOME \_\_\_\_\_ BUSINESS \_\_\_\_\_ CELL \_\_\_\_\_ EMERGENCY \_\_\_\_\_

BIRTH DATE, IF UNDER 21 \_\_\_\_\_ PARENT(S)/GUARDIAN(S), IF UNDER 21 \_\_\_\_\_

PLEASE CIRCLE YES OR NO (give details if necessary)

Allergic to any Medicine(s)	YES	NO	Asthma	YES	NO
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Diabetic	YES	NO	Allergies (be specific and list)	YES	NO
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Convulsive Disorder	YES	NO	Tetanus Shot Current	YES	NO
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Any other medical problem we need to know about? Please list:

Doctor-prescribed medications you/your child will take while at camp (list medications and dosage):

Make sure you/your child will have enough medication to last while at FBC. All medication to be checked by camp nurse upon arrival.

Special diet as prescribed by a doctor? YES NO If yes, specify:

Any exercise you/your child should not do? YES NO If yes, list:

Are you/Is child covered by insurance? YES NO (GIVE DETAILS. . **VERY IMPORTANT**)

Insurance Company \_\_\_\_\_

Employee Name \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Activity Agreement: I/We allow my/our child to participate in sport's related activities and competitions, including (check all that apply) \_\_\_ paintball \_\_\_ the blob \_\_\_ water slide \_\_\_ pool \_\_\_ iceberg \_\_\_ other sports. I/my child is of sound mind, body and health and is physically able to participate in the above mentioned functions.

I/We agree to hold Fort Bluff Camp/NACA and its agents harmless of any liability resulting from injuries or loss of property sustained by me/our child during any camp/tournament function. I/We give consent for me/our child to receive medical treatment by a registered nurse or licensed physician when deemed necessary by the Camp Director.

Signatures **(ALL THREE REQUIRED IF INDIVIDUAL IS UNDER 21)**

MINOR \_\_\_\_\_ DATE \_\_\_\_\_

FATHER/GUARDIAN OF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

MOTHER/GUARDIAN OF MINOR \_\_\_\_\_ DATE \_\_\_\_\_

<OR> ADULT (21 or older) \_\_\_\_\_ DATE \_\_\_\_\_

Once this form has been completed and signed, please make a copy. The original will be given to FBC; the copy will be given to the sponsor.

The above-mentioned student is physically fit and mentally prepared to participate in the camp activities.

SPONSOR \_\_\_\_\_

SPONSOR CELL NUMBER \_\_\_\_\_