



CAMP FEE: \$80

\$20 REQUIRED NON-REFUNDABLE DEPOSIT

must accompany the registration form.

Balance due upon arrival.

SCHOLARSHIP ASSISTANCE REQUESTED.

I am able to pay \$ _____ of the \$60 balance.

WINTERBLAST 2010

- Session One—January 22-24**
- Session Two—February 19-21**
(Transportation - From Chicago)
Ages 7-14

Please send _____
REGISTRATION FORM AND DEPOSIT to:

Camp Beechpoint Registrar
 3212 -125th Avenue
 Allegan, MI 49010
 1-800-991-CAMP
www.beechpoint.com

Camper's Name _____
 Parent's/Guardian's Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone (H) _____
 (W) _____ (cell) _____
 Circle one: Male / Female
 Birth date ____ / ____ / ____ Age _____



The following person(s) or organization has my permission to pick up the camper named, following their camp stay:

Deposit	_____
Date received	_____
Check #	_____
Balance Due	_____

BEECHPOINT HEALTH FORM

Mother's name: _____
 Phone: _____
 Father's name: _____
 Phone: _____
 Emergency contact: _____
 Phone: _____

MEDICATIONS: (MUST be in original container)

Medication	Dosage	Times
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations: Diphtheria, Measles, Polio, Rubella, Whooping Cough, Small Pox are current: ____ Yes ____ No
Tetanus Booster date: _____

Disabilities: _____
 Allergies: _____
 Special health considerations: _____
 Current infectious diseases: _____

DIFFICULTIES

- | | |
|---------------------------------|--------------------|
| ____ Headaches | ____ Diabetes |
| ____ Nosebleeds | ____ Heart trouble |
| ____ Asthma/hay fever | ____ Kidney |
| ____ Frequent colds/sore throat | ____ Bed wetting |
| ____ Skin rashes (specify) | ____ Bowel habits |
| ____ Menstrual difficulties | |

Past Medical Treatments: _____
 Emotional or behavioral problems: _____

Explanations: _____

INSURANCE CO. _____
Policy/Group#: _____

This health history is correct, to the best of my knowledge, and the person herein has my permission to engage in all camp activities, except as noted by our attending physician and myself. I give my permission to the physician selected by the Director of Camp Beechpoint to hospitalize, secure proper treatment for injections, anesthesia, or surgery for the child named above. Parents will be notified upon such need. I also give permission to the Beechpoint Health Officer to give routine, non-surgical treatment and do a lice check upon arrival at camp or bus stop. I give my permission to Camp Beechpoint to use quotes & images taken of my child while at camp. Such representations will only be used to promote the ministry & programs of Beechpoint.

Parent/Guardian Signature _____ **Date:** _____