



**BIG BEAR LAKE CHRISTIAN CONFERENCE CENTER**

Phone: 909 866-2360 Fax: 909 866-2857 Email: [Registration@bblccc.com](mailto:Registration@bblccc.com)

**FAMILY CAMP**  
**REGISTRATION & MEDICAL INFORMATION FORM**

PARENT LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ GENDER  M  F

PARENT LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ GENDER  M  F

CAMPER LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ GENDER  M  F

CAMPER LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ GENDER  M  F

CAMPER LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ GENDER  M  F

HOME PHONE (\_\_\_\_) \_\_\_\_\_ E-MAIL \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**IN CASE OF AN EMERGENCY** please contact: (For minors provide a friend or relative other than parent/guardian)

Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Daytime phone: (\_\_\_\_) \_\_\_\_\_ Evening phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

**CAMP REGISTRATION INFORMATION:** To be sure of available space, please call the PCCCI Office to check on camp availability).

**A. CAMP ATTENDING:** FAMILY CAMP \$135.00

**B. CAMP FEE:** All Camp Fees include a \$50 non-refundable deposit.

**MEDICAL INFORMATION**

**Does camper have:** Please check yes or no, and fully explain all yes answers on the lines provided.

- A.** A chronic or recurring illness or medical condition? (i.e. seizures, ADD, depression, etc.)  Yes  No
- B.** Any recent hospitalizations and/or surgeries? (include dates & reasons in explanation ):  Yes  No
- C.** Any allergies to medication? (include medication and reaction in explanation):  Yes  No
- D.** Up to date immunizations (as required by school district)?  Yes  No Date of Last Tetanus Shot (Given around ages 5 & 14): (Mo & Yr) \_\_\_\_\_/\_\_\_\_\_
- E.** Allergies?  Yes  No (If yes, please list all items allergic to and symptom(s) of allergy attacks in explanation.)
- F.** Asthma?  Yes  No - If yes, is it: Chronic/Seasonal/Exercise Induced? (circle one and explain)
- G.** Heart disease? Yes  No
- H.** A physical/mental/psychological condition requiring special treatment?  Yes  No
- I.** Insulin dependent diabetes?  Yes  No
- J.** Activity Restrictions/Limitations?  Yes  No
- K.** Hepatitis B vaccine series?  Yes  No
- L.** Dietary Restrictions? (We are not equipped to provide special diets)  Yes  No

**Please fully explain all yes answers here.** Indicate the letter of the item being addressed. Attach a separate sheet as necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is Camper currently taking any medications?**  Yes  No (prescription medication must be in original bottle with camper name and dosage and must be turned in to the Health Supervisor.)

Current Medication	Dosage(mg)/ Frequency	Type of Illness being Treated
1. _____	_____	_____

2. \_\_\_\_\_  
3. \_\_\_\_\_

*If more than 3 medications are being used, please attach a separate sheet. If this information changes before camp, please inform the Camp Nurse.*

**May Camper be given non-prescription medications** (i.e cough and cold medication, ibuprofen, etc.)?  Yes  No If yes, please list any over-the-counter medications that may not be given: \_\_\_\_\_

**FILL INSURANCE INFORMATION FOR UNACCOMPANIED MINORS ONLY** – Does camper have medical insurance?  Yes  No - If yes, provide a copy of the front and back of your card below:

FRONT OF  
MEDICAL CARD

BACK OF  
MEDICAL CARD

**PARENTAL STATEMENTS AND PERMISSION FOR CAMP**

**I GIVE PERMISSION** for the use of the following by BBLCCC for promotional purposes: (a) pictures taken while at camp; (b) quotations from evaluations/letters relating to camp experience; (c) video tape or audio recordings.

**I UNDERSTAND** that if the above-named camper participates in any illegal activity while at camp such as drinking alcohol, stealing or taking illegal drugs, they may be sent home immediately at the parent's expense.

**THE HEALTH HISTORY PROVIDED** on this form is correct and the camper herein described has my permission to engage in all camp activities unless noted above.

**I REALIZE** that individuals at camp can injure themselves without fault on the part of BBLCCC and release BBLCCC from responsibility for injury to this camper.

**I UNDERSTAND** that Big Bear Lake Christian Conference Center is located in a remote mountain region and that emergency care, even by ambulance, can take up to 15 minutes. The camper named above has no current condition that would warrant closer emergency medical care.

**I GIVE PERMISSION** to the medical personnel selected by the Health Supervisor, to provide emergency medical treatment for the above-named camper as deemed necessary. This may include transportation to a medical facility. In the event of an emergency in which I cannot be reached, I hereby give my permission to the physician selected by camp medical personnel to secure and administer treatment, including hospitalization for the above-named camper.

**X Signature of Parent/Guardian:** \_\_\_\_\_  
(Camper signs if 18 years or older)

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT FILL - HEALTH SCREENING – TO BE PERFORMED AT CHECK IN:**

Temperature\_\_\_\_\_ (if over 100 must determine whether or not can go/remain at camp)

1. Has camper/staff exhibited any of the following symptoms within the last 24 hours: sore throat, headache, nausea, vomiting, diarrhea, other flu like symptoms?  Yes  No
2. Does camper/staff display other transmissible conditions? (lice, pink eye, etc?) Yes  No
3. Has camper/staff been exposed within the last 48 hrs. to anyone who exhibited any of the symptoms in 1 or 2? (requires closer monitoring while at camp, not a reason to stay home) Yes  No
4. Explain any yes answers\_\_\_\_\_

Result of Screening: \_\_\_Attended Camp \_\_\_Quarantined at camp in isolation area \_\_\_Sent home/did not attend camp

Verified accuracy and/or need to update this health form  Yes  No

Medication (if any) collected ( for Minors) ?  Yes  No

Name of Health Supervisor performing screening\_\_\_\_\_ Date\_\_\_\_\_