



# Big Sandy

Camp & Retreat Center  
 52511 185<sup>th</sup> Pl., McGregor, MN 55760  
 PHONE: 218-426-3389  
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## Big Sandy Camp Wilderness Adventures

First time BSC camper? Yes No Gender: Male Female Date of Birth: \_\_\_\_\_

Camper First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Camper Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Camper Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Parent Email: \_\_\_\_\_

Parent Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Check 1 (or more) trip(s) you'd like to register for.

Name of Trip:	Age or Grade	Dates:	Cost:
BSCWA Boundary Waters Trip 1	18+ years old	May 24-29,2010	\$295
North Shore Climbing and Kayaking Trip	9 <sup>th</sup> -12 <sup>th</sup> graders	June 27-30, 2010	\$260
BSCWA Boundary Waters Trip 2	9 <sup>th</sup> -12 <sup>th</sup> graders	Aug. 9-14, 2010	\$295

I give permission to these people to pick up my camper. \_\_\_\_\_

The following may not pick up my camper. \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

**Please attach a copy of the front and back of insurance card.**

Group #: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

In case of emergency (if parent is unavailable), notify: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Please do not list "call block" numbers.*

### HEALTH HISTORY

	YES	NO		YES	NO
Have had chicken pox			Heart trouble		
Asthma			Skin problems		
Convulsions			Bed wetting		
Diabetes			<b>Allergic to:</b>		
Ear trouble			Penicillin		
Emotional problems			Insect stings		
epilepsy			other		

### IMMUNIZATION RECORD

	YES	NO		YES	NO
Polio			Whooping cough		
Small pox			Measles		
Diphtheria			rebellia		

Date of last tetanus booster: \_\_\_\_\_

List any activity restrictions, dietary restrictions, eating disorders, health problems and/or medication (Rx or OTC) relating to your child. Please give a description of any current physical, mental, or phychological conditions requiring medication, treatment, or special restrictions or considerations while at camp or during the trip.

If the health history identifies health problems or activity limitations, a physical examination must be performed by a licensed physician within one year before admission to camp or any off-site trips, including instructions relative to the limitation of the camper's participation in camp activities or medication requirements.

### CONTRACT

I give permission to Big Sandy Camp to dispense medication (Rx and OTC medication) to my child to manage illness and injury as directed by Big Sandy Camp medical protocol.

"In case of emergency, if I cannot be contacted, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child, as named above."

I understand that every effort will be made to protect and safeguard all campers. I understand a reasonable attempt will be made to contact me concerning any serious illness or injury involving my child. I agree not to hold Big Sandy liable for any illness or mishap from any cause whatsoever.

I also give the camp full authority in dealing with problems of discipline. I understand that any camper disregarding camp rules is subject to being sent home with no refund of camp fees. I understand that any camper who willfully destroys property will be held responsible and charged accordingly.

I give Big Sandy permission to use comments, photos and video of the camper named above in its promotional materials.

**I agree to and authorize everything within this contract and registration form.**

\_\_\_\_\_  
 Camper Signature (Parent if under 18)

\_\_\_\_\_  
 Date

Please enclose full camp fee

Additional \$5.00 enclosed for camp scholarship fund [ ]

My check for \$\_\_\_\_\_ is enclosed. Check # \_\_\_\_\_

[ ] DISCOVER

Please charge \$\_\_\_\_\_ to:

Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check [ ] MasterCard

Expires \_\_\_\_\_ / \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_

appropriate

Cardholder's

box [ ] Visa

Signature \_\_\_\_\_

*Office Use Only:*

Date	Amount	Check/ Charge #