BIG BEAR LAKE CHRISTIAN CONFERENCE CENTER
Phone: 909 866-2360 Fax: 909 866-2857 Email: Registration@bblccc.com

GUEST GROUP REGISTRATION & MEDICAL INFORMATION FORM

GUEST GROUP NAME_____ DATES OF ATTENDANCE_____

CAMPER LAST NAME _____ FIRST NAME _____

GENDER ☐ M ☐ F

HOME PHONE (_____)_____ E-MAIL _____

MAILING ADDRESS _____ CITY _____ ZIP_____

MINORS ONLY:

Age While Attending Camp _____

PARENT/GUARDIAN with primary custody: _____

Relationship: _____Phone numbers where you can be reached during the week of camp:

Daytime phone (_____)_____ Evening phone (_____) _____ Cell (_____) _____

The following person is legally restricted from seeing this camper:

Last Name: _____ First Name: _____ Relationship: _____

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: (____)_____

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 Health Supervisor.

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: _____

_____

INSURANCE INFORMATION FOR UNACOMMPANIED MINORS – 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: _____

HEALTH SCREENING – TO BE PERFORMED PRIOR TO ARRIVAL – FOR ALL GUEST:

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_____