Sacramento Methodist Assembly
Work Camp Registration Form

For office use only

CC #______________________ Exp__________________

Check # _________ $_____________ $_______________
Amount this camper

Check/CC From: ____________________________________

Date entered into database_____________by___________

Mail to:
Sacramento Methodist Assembly Registrar
PO Box 8
Sacramento NM 88347

Phone: 575-687-3414 **Fax**: 575-687-4219
EMail: guestservices@sacramentoassembly.org **Web site:** www.sacramentoassembly.org

Work Camp Fee is $25 per day. This includes Room and Board. A love offering for supplies used is encouraged.

Registrations must be complete and signed by a pastor (or designated staff person) and parent/guardian (if a minor). The registration fee must accompany the registration form. The signed Medical Form and registration fee must accompany the Registration Form, or form and money will be returned.

*****Please Print Legibly***** *****Please Print Legibly***** *****Please Print Legibly*****

MUST BE 14 AND OLDER FOR WORK CAMP. Health Form (on back) required for under 18 years. Requested for all others.

Custodial Parent/Guardian ________________________ **Additional Parent/Guardian:**_______________________

Address____ Address____
(Street or PO Box) (If different from other parent)

Home Ph# (____)________________________________ Home Ph# (____)________________________________

Work Ph# (____)________________________________ Work Ph# (____)________________________________

Cell Ph# (____)________________________________ Cell Ph# (____)________________________________

e-mail ____ e-mail____

Alternate Emergency Contact:_____________________**Relationship:**____________**Phone:**_________________

Camper Name ____
First (goes by) Middle Initial Last

Home Address ____
(Street or PO Box if different from parent) City State Zip

Birth Date _________________ Gender ___(F) ___(M) Grade This Fall _______Email ___________________

Home Church ____ Phone# ______________________

Church Address ____
Street or Box Number City State Zip

Pastor's Name____________________________________ Pastor's Signature ________________________
(Please print)

Who will pick up camper from SMA to take home when work camp is over______________________________

COMMENTS: Please list any special circumstances that might affect how the camper relates to others at camp. Examples: special dietary needs, short attention span, family or personal circumstances, etc.

____

Please use additional paper if more room is needed

I understand that **Work Camp Activities at Sacramento Assembly** may include but are not limited to activities associated with working in a rugged mountain setting such has landscaping, construction, operating power equipment and housekeeping. Other possible activities related to the time here might be sports related, water games, group games, archery, skating, mountain bikes, non-powered mountain push scooters, ropes course and climbing wall activities. I do hereby assume all risk of the above and any other ordinary risk incidental to the camp setting and will hold the NM Annual Conference, Sacramento Assembly and their Trustees, employees and agents harmless from any and all liability. I hereby grant permission to Sacramento Assembly to use photos of the above named camper, taken during activities at camp, for publicity purposes, in advertising materials, or on the camp's web site.

Participant (if adult) or Parent/Guardian's Signature

____

Don't forget to include your registration fee……If interested in donating a Scholarship for another camper, contact SMA at 1-800-667-3414

How did you hear about us? _____ Church ______ Word of mouth _______Media _____Other (please note)______________________

Work Camp Camper Medical Form

Camper Name: ______________________________________ **Camp Attending:** ________________________________

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. This form must be filled out to the best of your knowledge. (A copy of a school shot record is acceptable)

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – Haemophilus influenzae type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Influenza		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Asthma
		Food Allergies
		Other Allergies

Operations or serious injuries (dates) ____

Chronic or recurring illness or medical condition____

Dietary restrictions or special requests ____

Activities to be encouraged or limited ____

Current medications (send with instructions) ____

(Note: Camp not usually equipped to give shots)

Suggestions on health related information for camp personnel-short attention span, etc.

____

For Females: Has this person been educated about menstruation and related female health topics? ______ yes _____ no

To Best of My Knowledge ____

is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility. **I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

Participant if adult or Parent/Guardian Signature ____ Date _______________

Alternate Emergency Contact: ____

Relationship: ____ Phone # ________________________________

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company ____

Policy# _____________________________Group# __________________________

Insurance Address & Phone #____

Family Physician Name & Phone #____